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HISPANIC VETERANS: CONTRIBUTIONS TO THE NATION AND COMMUNITY, RECEIPT OF FED- ERAL VETERANS BENEFITS AND RELATED ISSUES

Y 4.V 64/3:103-59

Hispanic Veterans: Contributions to...

HEARING

BEFORE THE
SUBCOMMITTEE ON
OVERSIGHT AND INVESTIGATIONS
OF THE
COMMITTEE ON VETERANS' AFFAIRS
HOUSE OF REPRESENTATIVES
ONE HUNDRED THIRD CONGRESS
SECOND SESSION

SEPTEMBER 28, 1994

Printed for the use of the Committee on Veterans' Affairs

Serial No. 103-59



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HISPANIC VETERANS: CONTRIBUTIONS TO THE NATION AND COMMUNITY, RECEIPT OF FEDERAL VETERANS BENEFITS AND RELATED ISSUES

WEDNESDAY, SEPTEMBER 28, 1994

**HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC.**

The subcommittee met, pursuant to call, at 9 a.m., in room 334, Cannon House Office Building, Hon. Lane Evans (chairman of the subcommittee) presiding.

Present: Representatives Evans, Gutierrez, Long, Everett.
Also Present: Representatives Tejeda, Ortiz, Romero-Barcelo.

OPENING STATEMENT OF CHAIRMAN EVANS

Mr. EVANS. Good morning and welcome. During Hispanic Heritage Month, it is particularly appropriate for the Subcommittee on Oversight and Investigations to meet this morning to conduct a public hearing on Hispanic veterans' contributions to the Nation and community, VA benefits and services and related issues.

Hispanic men and women are no stranger to military service. They have served our country with dignity, distinction and courage and have always been among the first to answer their country's call.

But while Hispanics have a long and proud tradition of military service, the story of Hispanic veterans is not well known.

In my own district, for example, there is Hero Street. A street that is most fittingly named. After fleeing their homes during the Mexican Revolution, several families made their way to Silvis, IL. In Silvis they began building new lives on Second Street, which was a block and a half long.

As children, the boys and girls of Second Street felt the sting of discrimination and social injustice. But they were taught by their families that their street, their country and the ideals for which it stood were worth fighting for and defending.

During the last 50 years, over 100 young Hispanic men and women from this small community have answered our country's call and proudly served in our Armed Forces. Among their numbers, eight have made the ultimate sacrifice defending our freedoms and our liberty.

To honor their memory and in recognition of this remarkable record of service and sacrifice, Second Street is now known as Hero

Street. The extraordinary patriotism and self-sacrifice of these otherwise ordinary Americans will never be forgotten.

Hero Street and the Hero Street Monument should be considered a national memorial. They well represent the selfless contributions and most heroic sacrifices of all Hispanic Americans who have served in our country's military forces.

Today, the subcommittee begins a process of gathering information and shedding light on the military service of Hispanic veterans. The chair hopes this hearing will provide recognition to the contributions which Hispanic veterans have made to our Armed Forces and to the opportunities and challenges found in civilian life following military service.

Many people have assisted the subcommittee in its preparation for today's hearing, but the contributions of a few individuals are particularly noteworthy. The chair gratefully recognizes and acknowledges with thanks Congressman Luis Gutierrez from my State, and my fellow former marine Congressman Frank Tejeda, and the members of their staffs for their special contributions.

Actually, I must correct myself. Frank is still in the Marine Corps. He is still on reserve duty in the Marine Corps.

The chair also recognizes and thanks Jaime Rodriguez and the Joiner Center in Massachusetts for their special contributions in helping us prepare for the hearing today.

The subcommittee is scheduled to receive testimony this morning from many individuals and looks forward to the contributions that each witness will make. Without objection, the complete statements submitted by each witness will be included in their entirety in the printed record of this hearing.

Each witness will be recognized for 5 minutes to make an oral presentation, and witnesses are again requested to summarize from their prepared statement as needed to limit their presentation to 5 minutes.

The chair also notes Congressman Henry B. Gonzalez of Texas, the chairman of the House Committee on Banking, Finance and Urban Affairs, Congressman Lincoln Diaz-Balart of Florida, and Congressman Solomon Ortiz of Texas have all submitted written testimony for today's hearings, and their statements will be included in their entirety in the record, without objection. We appreciate their contribution to today's hearing.

[The prepared statement of Congressman Gonzalez appears at p. 74.]

[The prepared statement of Congressman Ortiz appears at p. 77.]

[The prepared statement of Congressman Diaz-Balart appears at p. 78.]

Mr. EVANS. The chair is particularly pleased to recognize and welcome Carlos Romero-Barcelo, the Resident Commissioner from the Commonwealth of Puerto Rico. His attendance is most appreciated by the subcommittee and we welcome him.

And Solomon Ortiz has just joined us. Solomon, we welcome you aboard. Solomon is a Congressman from Texas.

At this time let me yield to my colleague from Illinois.

OPENING STATEMENT OF HON. LUIS V. GUTIERREZ

Mr. GUTIERREZ. Thank you. First, I would like to express my sincere gratitude to Chairman Lane Evans for holding this hearing today. For the first time, Hispanic veterans have been given the opportunity to air their concerns and questions before the Veterans' Committee and to let the committee and the American public know of the many contributions they have made to our country and the many sacrifices they have made for the United States.

Mr. Chairman, I know everyone here appreciates the attention you have brought to the many issues surrounding Hispanic veterans. And, of course, I would like to especially thank my colleague on the Veterans' Affairs Committee who along with me worked with the chairman to make this happen, my colleague Frank Tejeda from Texas. I really have enjoyed working with Mr. Tejeda over the last 20 months.

I thought I was going to be the only Latino on the Veterans' Affairs Committee. I haven't checked the record but Frank has been here with me over the last 20 months, and I tell you it is quite a stark difference, and it is really good to have him here because of his courageous service in defense of our country and his understanding of veterans' issues.

And, of course, I am very delighted to see my good friend Solomon Ortiz, also from Texas, who has taken time out of what I know is a very busy schedule for him to be here and join us this morning.

To them, I say thank you.

And, of course, I would like to thank the witnesses, some of whom traveled long distances to attend this hearing. I sincerely appreciate the effort you have made to attend and present your testimony.

Not only is this hearing appropriately timed for the celebration of Hispanic Heritage Week, but I think it is also well timed to counter with ample evidence the debilitating rhetoric aimed at Hispanics in general and immigrants in particular. Immigrant bashing has become all too popular, especially here in Congress. People are searching for easy targets to blame for the serious problems facing our society. Unfortunately, too many of us have become the targets.

But today, we will not hear uninformed rhetoric. We will hear about the sacrifices and the contributions of Hispanic veterans, and we will hear about the tremendous work that Hispanic organizations have undertaken to serve the veterans' community and indeed this our great Nation.

Too few people realize the sacrifices that Hispanics have made as members of our Armed Forces. In some States they comprise the majority of soldiers sent overseas. They represent a disproportionate number when compared to the U.S. population as a whole. And when these veterans returned from serving their country they have again suffered disproportionately from mental and social afflictions such as PTSD and homelessness.

After we listen to the testimony presented here today I hope we will not simply file it away in the back of our mind, but we will begin to formulate the information we have received into productive answers and programs for our veterans community.

This committee will be presented with testimony about programs that are working to help veterans, programs that need improve-

ment and programs that are needed but simply do not exist. Let's not leave our veterans with more talk. They deserve more. They deserve action, dedication and commitment. It is our turn to fight for them, to ensure that they enjoy the same freedoms they fought so hard to protect for the rest of us.

Thank you very much, Mr. Chairman.

Mr. EVANS. Thank you.

The gentleman from Texas, a member of the committee, Congressman Frank Tejeda.

**OPENING STATEMENT OF HON. FRANK TEJEDA, A
REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS**

Mr. TEJEDA. Thank you, Mr. Chairman. And again I would like to thank you for holding this first hearing to explore issues affecting Hispanic veterans. It certainly gives us a great opportunity to gather information on problems confronting Hispanic veterans and to highlight the contributions of Hispanic veterans in our Nation's Armed Forces.

Hispanic veterans have always played a major role in our Armed Forces, and in Texas we have many Hispanic veterans that received the congressional medal of honor, including Lucian Adams, who is on my staff, and who many in the audience are helping in dedicating a highway named in his honor, hopefully in the very near future—October 29th, I believe.

And in my community the Department of Veterans Affairs has excelled in reaching out to the veterans. Yet access to care is a major problem that I hear from all veterans in south Texas, and certainly the VA needs to address this very serious problem.

And I'm sure that in other regions of the country many problems exist that this hearing will give Hispanic veterans the chance to voice their concerns and offer possible solutions. And after today we here in Congress should not forget the successes and the failures mentioned, but should use that information to improve the opportunities available to Hispanic veterans.

At this time, Mr. Chairman, I would like to take the opportunity to recognize a couple of individuals, some friends from San Antonio; that is, Carlos Martinez of the American GI Forum. Welcome, Carlos.

And also Jose Coronado, the Director of the Audie Murphy Memorial Veterans Hospital, who will be on one of the panels today. Jose, welcome. Thank you very much.

Mr. Chairman, thank you very much.

Mr. EVANS. Thank you.

I would also like to recognize my other colleague from Texas, Congressman Solomon Ortiz, a classmate of mine, coming here with me in 1982. Welcome to the committee, Solomon.

**OPENING STATEMENT OF HON. SOLOMON P. ORTIZ, A
REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS**

Mr. ORTIZ. Thank you, Mr. Chairman. And first of all, let me thank you for your leadership and your concern. I can assure the veterans that we have a chairman who has got his heart in the right place, and members of the subcommittee. And thank you for allowing me to be here and to testify.

If you will allow me, I'll take the 3 minutes to—

Mr. EVANS. We recognize you for that purpose at this time.

Mr. ORTIZ. Thank you, Mr. Chairman. Of course, thank you for allowing me this opportunity to present testimony concerning the contributions and concerns of Hispanic veterans.

As a veteran myself, I am pleased to advocate the concerns of the veterans in south Texas, and across the country. Veterans are one of the most important national resources in our country, and it is always a privilege to hear the wisdom and to learn about the needs of so many brave men and women who have served this country well with distinction and honor.

In particular, Mr. Chairman, I am pleased to discuss the successes of Hispanic veterans. As with all veterans, Hispanic veterans have been willing to sacrifice their all for this country in the name of liberty, independence and freedom. These veterans have served their country honorably and have been willing to pay the ultimate sacrifice—their blood—for our freedom.

Hispanic veterans, which number over 925,000, are a substantial element of the veterans community in the United States. The military service of Hispanics reflect their beliefs in the United States. In fact, they have participated in many wars—the Revolutionary War, and later the Civil War where Hispanics served in both the Union Army and the Confederate Army and the many conflicts in which the U.S. has served. We appreciate what you have done for our country.

We enjoy privileges and rights in the U.S. because of the efforts of many Hispanic veterans.

Hispanics have made an investment in the armed services and they deserve to be recognized for their valor. They also deserve the services and treatment that all other veterans receive. I would like to echo what my good friend, Mr. Tejeda has said.

I represent a district that is 175 miles long. We are in need of a hospital. The Department of Veterans Affairs does a great job with the clinics that we have, but when we have veterans who need special care it takes 5 or 6 hours to get them to San Antonio. I represent the southmost part of the district, which is Brownsville.

But I know that with your efforts, Mr. Chairman, and the efforts of the members of this committee, we will see activity on that front. I know you all care because I have seen you in action. All those members care. Lane and I were in the same class and I have seen him in action. He really cares for the veterans. He believes in what they have done.

And again, Mr. Chairman, thank you very much for allowing me, and I bow to my good friends, the veterans who are here with us today, and I respect them very much.

Mr. EVANS. Thank you.

We are pleased to recognize Congressman Carlos Romero-Barcelo for any remarks he would like to make at this point.

OPENING STATEMENT OF HON. CARLOS ROMERO-BARCELO, A REPRESENTATIVE IN CONGRESS FROM PUERTO RICO

Mr. ROMERO-BARCELO. Thank you very much, Mr. Chairman, for allowing me to be here and to present my remarks. I want to congratulate you and the committee on having raised this issue and

holding hearings on the contribution of Hispanic veterans and also the conditions of the services for those veterans.

Just this weekend, the Secretary of Veterans Affairs was in Puerto Rico and saw the conditions of the outpatient clinics in the VA Hospital in Puerto Rico and the overcrowding of those conditions.

Veterans in Puerto Rico participated, as veterans have participated in all the wars. But not only have they participated in all wars honorably and also patriotically, but they were also participating at a time when there was discrimination in the armed services, when there were separate units, and there were Puerto Rican units.

One of those Puerto Rican units, as a matter of fact, an infantry regiment in Korea, was an outstanding unit that covered the strategic withdrawal of the Marines when they had to retreat from northern Vietnam. And, even though we're number 26 in population, Puerto Ricans suffered about 14—was number 14 in casualties and number 4 in dead in Vietnam.

And yet the discrimination that existed does not exist any more, at least in the service, has still existed in the assignment of appropriations of funds for the veterans services in Puerto Rico. It has happened for the past 15 years. And the overcrowding conditions of the veterans' outpatient clinics will not be tolerated in any State of the Union. Fortunately, the chairman with the support of this committee and your support and others, we finally did get an appropriation for the outpatient clinics.

I just want to take a little bit of time, very short, to explain the reason why the overcrowding and there has to be special attention paid to those needs of the veterans, because veterans are discriminated in other programs, and their families are discriminated in other programs.

One of the reasons why there is such a great overcrowding in the facilities in Puerto Rico is because the veterans in the first place have a lower level of income. Not only do they have a lower level of income, if they're poor they don't get SSI. AFDC is only about 10 percent of what it is for the rest of the Nation.

They don't get earned income tax credit. So, they're still poor. They remain poor. Instead of trying to bridge that gap that gap has widened.

Medicaid is not available in Puerto Rico. So that the poor veteran has no option other than the VA services, the hospital services and the outpatient clinics. Otherwise, he has to go to public clinics, which are definitely inferior. We're trying to improve that in Puerto Rico but there is not—because we only get 10 percent of the funding of Medicaid, the medical and hospital services in Puerto Rico are not up to what they should be.

So, instead of having 10 to 14 percent of the veterans in the area using the facilities, the facilities are being used by about 40 percent of the veterans in the area. So that creates a severe overcrowding.

I just wanted to bring these facts and these conditions to the attention of the committee, so that as we go forward in this investigation we realize that special attention has to be taken to these conditions in Puerto Rico because the veterans are being still discriminated in all of the services.

In Title I, for instance, in education, grandchildren of veterans are being given only half of what the other poor children in the nation are being given, and I ask that the Administration give me—I would like to have some kind of explanation that I can give to the children of these veterans, the grandchildren, why they are U.S. citizens, they still don't get the same benefits and the same opportunities in education as the rest of the children in the Nation, the grandchildren of other veterans and the grandchildren of others that are not veterans.

But I wanted to bring this situation to the attention of this committee, so that as we go forward in the analysis of the conditions of veterans and compare them throughout the Nation that these conditions be kept in mind.

Thank you very much for the opportunity to be here.

Mr. EVANS. Thank you very much for your informative testimony.

Congressman Tejeda.

Mr. TEJEDA. I'd like to join in the comments of my distinguished colleague Carlos, but I must take issue with one comment he made, and the chairman would understand and we're not taking anything away from the courageous and valiant stand of the Puerto Rican infantry regiment.

He mentioned that the Marine Corps retreated. As the chairman knows, there is no such word as retreat in the Marine Corps vernacular. It was a retrograde movement, which is an orderly advance to the rear.

Mr. EVANS. Advance to the rear. Well, we thank you for that clarification.

We are very pleased to be joined by Congressman Everett from Alabama, and we will be pleased to recognize him for any opening remarks he might make.

Mr. EVERETT. Thank you, Mr. Chairman. I, too, want to thank you very much for calling this important and necessary meeting today. I applaud you for that.

And I concur fully with the remarks you and my colleagues have made. And, while I'll submit a statement for the record, there is not much more I can add to it, because it is very, very good.

I would like to apologize now because I have another meeting going on as we speak. But I do want to say how much I appreciate you honoring us with your presence here today.

Thank you, Mr. Chairman.

Mr. EVANS. We thank you for your regular participation in our hearings.

[The prepared statement of Congressman Everett appears at p. 73.]

Mr. EVANS. I have been asked to announce that the Chief Minority Affairs Office of the Department of Veterans Affairs cordially invites all veterans present to a luncheon today, as we announced earlier, starting at 12 o'clock in room 340 of this building. Everyone is encouraged to participate in that luncheon.

The first witness this morning is Jake Alarid, the National Commander of American GI Forum of the U.S. The American GI Forum is the oldest and largest Hispanic veterans organization in the Na-

tion, and the subcommittee is very pleased you have traveled from Whittier, CA, to testify today.

Your complete statement will be made part of the record, without objection, and we ask you to identify your national officers accompanying you.

**STATEMENT OF JAKE ALARID, NATIONAL COMMANDER,
AMERICAN GI FORUM OF THE U.S., WHITTIER, CA, ACCOM-
PANIED BY CARLOS MARTINEZ, AL GALVAN, AND ARTHUR
SOLIS**

Mr. ALARID. Thank you, Congressman Evans.

I have some people here from the American GI Forum. On my left is Carlos Martinez, National Director of Veterans Outreach Programs, San Antonio. Mr. Art Solis from Kansas. He is our legal adviser. And I also have a colleague of yours from Illinois.

Mr. EVANS. Would you like to join us at the witness table? A chair is there.

Mr. ALARID. Honorable Congressman, I want to thank Congressman Tejeda for clarifying that remark. I am also a Marine Corps veteran.

Good morning. My name is Jake Alarid. I am honored to serve as the National Commander of the American GI Forum of the United States, the Nation's largest and oldest Hispanic veterans organization in the country.

I appreciate the opportunity to come before this committee on this historic occasion that makes this the first time ever that a congressional committee listens to the problems, the needs and the views of the Hispanic veteran.

Americans of Hispanic descent have honored us throughout the history of this great Nation of ours with valiant service in defense of our country. It is widely known that on a per capita basis the Hispanics have received more Medals of Honor than any other ethnic or racial group in the history of the U.S.

It is also time to recognize other unique conditions that actually exist for Hispanic veterans. Given the time allotted it is not possible to cover all problem areas in detail at this session. Perhaps this committee will grant us periodic opportunities to continue this dialogue. I have also provided a more detailed written testimony for the committee to review as may be required for your proceedings.

In today's testimony I wish to raise five distinct areas of priority need. Let me begin with touching on the issue of post traumatic stress disorder in Hispanic Vietnam veterans.

The National Vietnam Veterans Readjustment Study (NVVRS) found that the prevalence rate for current post traumatic stress disorder was highest among Hispanic veterans of the Vietnam theater at an astounding 27.9 percent. Black, white and other theater veterans had rates of 20.6 percent and 13.7 percent, respectively.

The American GI Forum of the United States strongly recommends that Congress authorize and direct the Department of Veterans Affairs to conduct clinical and research studies of PTSD and other stress-related psychological problems stemming from combat in Hispanic Vietnam veterans. Specifically designated funds should be allocated to finance this research.

Employment and training services is another critical area of concern for Hispanic veterans. The Bureau of Labor Statistics reports that Hispanic veterans have an employment rate in excess of 8 percent. That in itself is a critical issue.

But the American GI Forum also believes that many other Hispanic veterans are chronically underemployed because of the lack of skills and training. The central issue to be addressed here is the limited funds available for the Jobs Training Partnership Act (JTPA), the primary employment and training system in our country.

The Title IV(C) section of JTPA sets aside specific funding for veteran programs. The amount available, however, is less than 1 percent of the total JTPA funding. That pittance is bad enough, but it gets worse when local job plans under JTPA fail to include veterans as a target group because of the misconception that veterans are being taken care of by Title IV(C) section.

Our organization urges the U.S. Department of Labor to issue strong directives to all State Governors and all Private Industry Councils that administer JTPA funds to include veterans as a performance standard requirement for their mainstream programs. Veterans make great employees if given an ample opportunity for training.

Homeless veterans is another great concern to our organization. For many Hispanic veterans, homelessness is a fluid state as they drift in and out of temporary arrangements between family members and friends. Within the Hispanic culture, the extended family is a common occurrence and generally includes an obligation to extend a helping hand as in "mi casa es su casa," meaning "my house is your house."

The unfortunate side of this benevolent effort is that in many cases the host family is already economically disadvantaged and that the added burden of supporting another mouth to feed puts the host family at risk of becoming homeless themselves.

The American GI Forum supports the continuation of comprehensive programs targeting homeless veterans. It is our further recommendation that veterans' community-based groups be utilized to reach out to their lost brothers and that the programs be comprehensive in design to address the array of problems each homeless veteran presents.

Homelessness for any American is intolerable. Homelessness for veterans is a national embarrassment.

Another major issue facing our constituencies is access to and provisions of health care for Hispanic veterans. The National Vietnam Veterans Readjustment Study data and other studies found that Hispanic veterans utilize VA and other health care services much less than white veterans or black veterans.

The American GI Forum of the United States recommends that Congress authorize and direct the Department of Veterans Affairs to conduct a study to determine if VA health care facilities and PTSD resources are geographically located to provide for the treatment of Hispanic veterans.

The VA should be encouraged to use a wide range of innovative approaches for health care delivery and aggressive outreach such

as community-based clinics to improve access in those areas that presents special problems for Hispanic veterans.

In completing this testimony, I would like to focus attention on one common thread throughout my presentation and those of others coming before this committee today. That is the permeating atmosphere of hearsay evidence throughout much of our presentations. Why? Because the government continues to fail our constituency in documenting Hispanics as a specific statistical measure in many of its reports. We must know factually where we stand in order to correct the problems.

For this reason, the American GI Forum has asked for a GAO study on the status of Hispanic veterans. The initial request was made by Senator Orrin Hatch and supported by the Congressional Hispanic Caucus in August 1992. Unfortunately, to date GAO evidently continues to hold this request as a low priority because nothing has been done about it.

I present it to this committee in hopes that you too will join the call for GAO action in this study. How can we proceed with constructive initiatives on problems that we clearly sense in our community but cannot document?

Without studies to determine casual and correlative relationships, effective strategies to address the specific needs of Hispanic veterans cannot be developed and implemented. We need help and that is why I am asking for this committee's.

It is also my recommendation that the Department of Veterans Affairs initiate hearings in Hispanic populated areas such as Northern California, Southern California, San Antonio, Chicago, Albuquerque, Denver, Phoenix, AZ, and like the Congressman from Puerto Rico said, in Puerto Rico.

I thank you for this opportunity and I strongly encourage you to continue your investigative initiative on behalf of Hispanic veterans.

[The prepared statement of Mr. Alarid appears at p. 81.]

Mr. EVANS. Commander, thank you. We appreciate your opening remarks on this historic day, this first hearing on Hispanic veterans issues. That you would be the lead-off witness I think is an important step forward, and we look forward to working with you in the future.

The GAO study you mentioned in the last part of your remarks, it disturbs me this study hasn't been given high priority. I would be glad to work with my colleagues here today to contact the GAO and weigh in with them that we would like this to be upgraded as a priority and see what progress we can make.

I just have one basic question. National health care reform has been declared dead this year for all intents and purposes, but I understand the problems probably in many communities are going to be aggravated, particularly with the VA being underfunded during the 1980's.

Has your organization taken a position on health care reform and where we might be going? Because I see some of the problems being a lack of access probably to primary care facilities that aren't accessible to people in minority communities. Could you give us an overview of your position?

Mr. ALARID. Yes, we did. At our last convention, in August in Santa Clara, CA, the American GI Forum took a position to support the universal health care program to be implemented in the United States for everybody. So, the American GI Forum has taken a position and supports health care.

Mr. EVANS. The chair yields to the Congressman from Illinois.

Mr. GUTIERREZ. Thank you, Mr. Chairman.

Mr. Alarid, I know of the GI Forum's excellent work on behalf of veterans in the Chicago area community through Mr. Al Galvan to your left, the Illinois Director of the GI Forum, and I would like to thank Al for being here with us this morning.

Al has introduced me to the scholarships the GI Forum provides to college-bound Hispanic students. The GI Forum should be commended for its dedicated community service.

Mr. Alarid, I would be very interested to hear in more detail about the other side of the GI Forum, the veterans outreach program. I understand the program provides job training and education as well as job placement. Could you tell us a little bit more about the program?

Mr. ALARID. Yes, sir. We have a veterans outreach program Central Office in San Antonio, TX, and we have branches in different areas of the United States. Mr. Carlos Martinez here is the Veterans Outreach Program Director, and perhaps I'll relate that question to him.

Mr. Carlos MARTINEZ. Thank you, Mr. Alarid.

Yes, sir, we do have these program services available in 8 different cities around the country. We do not have, obviously, all the resources we need, but the program is very comprehensive in nature. We provide employment and training through the JTPA Title II(a) program. We provide training through the Title IV JTPA also.

But we also provide Agent Orange programs, and we use all of these services to complement one another. We will use the counseling services, post traumatic stress, for those individuals that require it. We will process later on into the employment and training aspects.

We do have also a homeless veterans reintegration program that we provide in San Antonio. We would like to replicate that in other areas. It is an initial effort, but we can see already the tremendous need, not only for the individual veterans but for a growing concern of homeless families now.

That is something that we are addressing by utilization of the VA houses that are made available on a lease basis for a dollar a year. We have three such homes in San Antonio providing services for homeless veterans' families.

We are also in the process of acquiring some transitional housing. We are trying to secure some of these type structures through the RTC. We have not been successful at this point.

A lot of these properties that are available now are just not suitable in their current condition, and renovation is extensive, especially as it may pertain to some lead-based problems and what have you in the older structures.

But in any case, the program is designed to reach out into the community, talk to the veterans in their environment. That was the initial thrust of the program back in 1972 when the American

GI Forum first sensed the change and the veterans returning from Vietnam were having different types of problems, and this is why the program developed as an outreach effort. And it was probably the first of its kind in the country.

So, we have—over the last 22 years, we have sophisticated the program to a great degree. It should be replicated. It should be studied and replicated in many other sectors.

Mr. EVANS. Would the gentleman yield?

Mr. GUTIERREZ. Yes.

Mr. EVANS. So, it hasn't been a lack of willingness for the RTC to work with you? As you said, the properties available are not suitable for your purposes?

Mr. Carlos MARTINEZ. In our geographic area, that is correct, sir. We have had some good relations with RTC. They have made some offers. The properties that were made available to us, however, were not suitable in their current state.

Mr. EVANS. Thank you. Yield back to the gentleman.

Mr. GUTIERREZ. Thank you, Mr. Chairman.

Well, I just want to say that I would like to echo the statement of the chairman about the GAO report. I think we need to give that more priority. And I know we are going to be working with him, and now that I know that you are based out there in San Antonio, I know that Mr. Tejeda will be working very hard on that request.

I think that is a part of what we wanted to hear. I remember during many discussions with Congressman Tejeda about putting this first hearing together, we talked about listening to things that needed to be done. So, I appreciate your testimony.

We also know that we are going to hear a lot of testimony today during our discourse about our contributions. We wanted to balance it out, and I think you have done an excellent job here this morning.

Thank you to the GI Forum, and thank you to my good friend Al for always being there for the veterans in Chicago and the State of Illinois. You have a great Director in Illinois.

Thank you.

Mr. ALARID. Well, thank you very much. And thank you, sir.

Mr. EVANS. The gentleman from Texas, Mr. Tejeda.

Mr. TEJEDA. Thank you, Mr. Chairman.

I would just once again like to welcome the members of the GI Forum, but also thank them very much for their tireless efforts on behalf of all veterans, especially Hispanic veterans.

I know that the organization was born with Dr. Garcia in Corpus and that it was because of the treatment that many of our Hispanic veterans were receiving when they were returning from World War II. But they have done an outstanding job, and I salute you for a job well done.

You know, in your testimony you mentioned that the JTPA set-aside for veterans programs and that the funding amount to less than 1 percent of the total JTPA funding. Could you explain how the Department of Labor could improve on this program, or what recommendations you would have?

Mr. ALARID. Well, again I think that the Department of Labor has to work with the PICs in the different issue—give direction to the PICs in the different areas where we have the funding to take

into consideration the monies for veterans outreach programs, because I think, like we stated before, they fail to consider veterans because they think it is already being taken care of. So, I think that is what we would like to recommend.

Mr. Carlos MARTINEZ. Just to expand on that a little bit, Congressman Tejeda, the Title IV(C) seems to be an advantage at first glance, but it is really a detriment when you consider the fact that so many of the other mainstream programs turn away from veterans because of the misconception that veterans are already being taken care of by the Title IV(C) section of the law.

But, in reality, the employment and training funds under Title IV(C) is less than \$10 million nationally. Yet one SDA in any major city will exceed that alone under the Title II(a) program, which is the mainstream general adult programs. But in each one of those programs it is our recommendation that they should have a performance requirement to assist the veterans correlative to the population that is in their geographic area, service area.

And I think this could be easily done if the Assistant Secretary of Veterans Employment Training Service, the Assistant Secretary of the Employment and Training Administration which administers the Title II(a) funds could send out a joint issuance of some sort directing all the Private Industry Councils to work a performance requirement into their job plans.

In lieu of that, obviously, there is always the option to change the legislation, but that may be a more difficult process. I believe that we can get the Assistant Secretaries to coordinate on this, perhaps with support from the Secretary and certainly this committee.

It would be very advantageous for veterans. It would offer immediate relief, and it would not cost any additional funding.

Mr. TEJEDA. Let me ask you, you know, we have the Department of Veterans Affairs, which is the primary, shall we say, agency dealing with veterans' needs and concerns. But also each Department, whether it is Labor or HUD or Education, you know, have their own veterans sections or veterans programs.

In your opinion, is this working well? Is there coordination between the different agencies between the different programs? I guess the bottom line is does the left hand know what the right hand is doing when it comes to veterans' assistance and veterans' programs between the different agencies?

Mr. Carlos MARTINEZ. I believe, sir, to some extent it has worked well and is working much better than it used to work. A lot of these initiatives, I think, is still left up to the localities. The individual programs need to coordinate with one another.

I know that in San Antonio, as an example, we work very closely with the Audie Murphy Hospital in serving the needs of our homeless veterans through our homeless veterans reintegration program. Through the Department of Labor funds that we receive under the McKinney Act we provide the outreach effort, we provide the counseling. Through the VAS program that VA provides we offer them the sheltering that they need. And, obviously, through their PTSD Center we take care of some of their PTSD problems and the substance abuse problems that many of these individuals suffer.

So, yes. In the localities, at the local level we do work very well. I think, perhaps, at the national level it could be improved somewhat.

Mr. EVANS. The other gentleman from Texas, Congressman Ortiz.

Mr. ORTIZ. Mr. Chairman, I don't have any questions.

I would just like to take this opportunity to compliment the GI Forum. In fact, the organization was born in my hometown of Corpus Christi. He didn't mention that.

Of course, their founder, Dr. Hector Garcia, is now very ill. They have always done a good job, and I just want to compliment the GI Forum for being with us today and telling us a story that we need to know.

Thank you very much, Mr. Chairman.

Mr. EVANS. Thank you.

The gentleman from Puerto Rico.

Mr. ROMERO-BARCELO. Thank you, Mr. Chairman. I have no questions for them.

I just want to also congratulate them. I think they're expanding their services in Puerto Rico and we appreciate that. I think the veterans are very, very happy with those services there.

Mr. ALARID. Yes. We hope to go down to Puerto Rico and have the GI Forum establish some chapters in that area.

Mr. ORTIZ. That might be helpful. Thank you.

Mr. ALARID. Okay. You're welcome.

Mr. ROMERO-BARCELO. Thank you.

Mr. EVANS. We are very pleased to be joined by Congresswoman Jill Long from the State of Indiana, a very active member of our committee, and would recognize her for any remarks or questions she might have.

Ms. LONG. Thank you, Mr. Chairman. I don't have any questions, but I would also like to commend this panel for the fine work that they are doing, and also for their fine testimony today.

And also to our chairman, who does an outstanding job working tirelessly on behalf of veterans in chairing this committee. And thank you for holding this hearing.

Mr. EVANS. Thank you for participating.

Two weeks ago a witness before this subcommittee reported that Governor Cuomo of New York has designated veterans, particularly Vietnam theater and other combat duty veterans, minority veterans, disabled veterans, and recently separated veterans as a "special emphasis priority group" for the Job Training Partnership Act. We think that is a good step forward.

If we can carry that message to the other States where we have that high unemployment level, it would be very helpful. So, if you can spread that word it would be very helpful to us.

Mr. ALARID. Certainly.

Mr. EVANS. Commander, thank you again. We salute you and we applaud you now for your fine testimony.

Mr. ALARID. Thank you very much. [Applause.]

Mr. EVANS. The members of our first panel are Porfirio Torres-Gonzalez, Tony Santillanes, and Juan Rosado. Mr. Torres-Gonzalez is an author from Willingboro, NJ. Tony is a Navy veteran from

Rio Rancho, NM. Juan is President of Puerto Rican Veterans Association of Philadelphia, PA.

We will proceed with Mr. Torres-Gonzalez once he is situated.

I should have also recognized a very high ranking VA official that I am pleased is here and is going to be promoted in the near future to the head of Selective Service, Gil Coronado.

Gil, would you stand up? We salute you. [Applause.]

Mr. EVANS. You may start when you are ready.

STATEMENTS OF PORFIRIO TORRES-GONZALEZ, WILLINGBORO, NJ; LOUIS ANTHONY "TONY" SANTILLANES, RIO RANCHO, NM

STATEMENT OF PORFIRIO TORRES-GONZALEZ

Mr. TORRES-GONZALEZ. Mr. Chairman, honorable Members of Congress, distinguished guests and fellow comrades, it is a pleasure that I address you with some historical memorabilia in words citing a few of the many accomplishments of the Puerto Rican as a militia defending the democratic principles of the world.

But let me go first into something that came up to my mind, and it is a story about a comedian, very well known, Mr. Sunshine LoGroño from Puerto Rico. He recalls an airplane full of people flying from New York to Puerto Rico. And every time, as you know, the hostess has the habit to address the people on safety features of the plane and also the safety procedures in general, and also presenting themselves.

Everytime that the head hostess mentioned the names of the persons assisting her, she said "My name is Sylvia Saunders. I welcome you aboard the plane. Everyone of the passengers clapped their hands. Accompanying me is Ms. Helene Eliot from Wisconsin [claps]. In fact, she keep calling names, all of them from different States until she get to start calling the crew.

She said, "Definitely I have to speak about the great navigator here on the plane, Mr. William Eliot from Wisconsin [claps]. The copilot is Mr. Tom Handy from Chicago [claps]. And last but not least the pilot of the plane, Mr. Jose Flores from Puerto Rico," and everyone said "Oh, we're going to crash."

This is a fact that happens sometimes. I am going to speak to you about some memorabilia of the Hispanic or the Puerto Rican, because searching through the historical record of the Puerto Rican militia we will discover and look into the sacrifices and love to our beloved country of those who served and the ones that are still doing so and will do so if needed in the future.

Just like the Minutemen in 1776 who got an important call to protect and help mold the structure of this government system, the Puerto Rican was called to defend the island five centuries ago and they fulfill that obligation under the first Governor of the island Don Juan Ponce de Leon.

The spirit of freedom resurged in later years, in the year 1797 to be more exact, when in Puerto Rico the government organized Urban Militias and so-called Volunteers Institute. They were called to defend against a British attack on the island.

A distinguished motto expressing the alertness of the Puerto Rican State Guard is an indication of the standards of the units always ready to respond. A lieutenant governor and historian named

Luis A. De Casanova in pages of history books, clearly denotes the well-deserved motto, "En alerta" meaning "always on alert."

Well, after the Spanish-American War, the first Puerto Rican was enlisted in the year 1899. Just one year after the United States historical landing on the shores of the island, a second lieutenant commission was granted to a gentleman named Blas Nadal. And then there were seven more Puerto Ricans, five years later, that were enlisted in the U.S. Army, even before the Puerto Ricans became American citizens.

I have to cite the name of a great regiment once again like my dear Commissioner here cited before, and it is the 65th, nicknamed the Borinqueneers, which is analogy or the same to say native Puerto Ricans. Today the 65th is inactive, but it is ready to be present at any time needed. The 65th proudly campaigned not only in Korea, it campaigned in North Africa also and the Eastern Front of Europe.

I myself feel proud of being part of that distinguished unit during the Korean War. And just like the Commissioner said before, it is a right judgment to say that it was one of the units that got the most Purple Hearts. I, myself, was a recipient of one in my first baptism of fire, leading an infantry squad next to the infamous Pork Chop Hill. I could clearly feel the bloodstreaming down of many of the brave warriors that fell there.

My first tour to the war in Vietnam, as an adviser, a coven, I was presented with a Silver Star for gallantry in action as I singlehandedly faced two battalions during the Tet Offensive of 1968. And later on, myself singlehandedly leading the charge, I overcame many enemy positions causing great casualties. I had to do that because otherwise I could not survive, and the people with me could not do it either. I was returned to Vietnam and served a second tour as First Sergeant with the 101st Airborne Division and was badly wounded and awarded a second Purple Heart and other medals.

I do have to credit my beloved father also who distinctively served in the American Army from 1914 to 1917, three years, even before Puerto Ricans became American citizens, as I said before. To me he was one of the persons that paved the way to make Puerto Ricans become American citizens later. He served proudly.

Recalling the numerical designation of some of the outstanding units that are today still ready to be called anytime and to serve are the 296th Infantry and the 245th Infantry regiments. Now, they have other numerical—other designations. They are called the battle groups or maybe brigades, but still have the same numerical designations.

And I cannot forget a magnificent group, the 295th, which was the first one organized, in 1920, under the American control. The 295th, a magnificent unit that is still active as part of the State Guard today. I have to say that it was organized on a very particular date to me because on the same date 12 years later I was born. The unit became active the 2nd of June of 1920.

I have also to cite a man that one time came as a part of a committee to meet with the distinguished and great President John F. Kennedy. He came to the White House with the Governor. He wrote beautiful poetry expressing the feelings of people.

The name of the man was Don Rafael Hernandez and was addressed by President Kennedy as Mr. Cumbanchero.

This man, with feelings of love for his country, he volunteered himself in the first world war to serve as a soldier, while he was residing in New York. Another song writer with beautiful expressions was a man called Pedro Flores who wrote a very tender song called "Despedida" meaning "farewell" in English.

In this musical masterpiece he cites the feelings of a young soldier, a young Puerto Rican, having to leave his country, his friends, his sweetheart, to go and protect the country and bear arms just like everybody else on call. But the most that he resented was leaving his mother by herself with nobody to take care of her. He did not resent to go and fight for the country.

Today, the Puerto Rican as part of the American military forces continue to render service, on call very proudly, with distinction, around the world from Grenada, Korea, Vietnam, Panama, Dominican Republic, Honduras, the Berlin Airlift, Somalia, Kuwait, and now Haiti among others.

The Puerto Rican militia, regardless of the branch of service, is part of what we have accomplished, and continue to do his duty defending the democratic ideals.

I will never forget the early fifties when I could not speak English fluently. I had learned some in school, and the first 16 American soldiers from the stateside arrived in Puerto Rico to be part of the regiment that I belonged which all the members were Puerto Ricans. There was a dilemma on who was going to try to communicate with them in the matters of training. I volunteered myself. I stood up and volunteered.

I knew I had some inconvenience expressing myself, but I think I felt up to what was needed at that time. And after me there were many others that did the same.

I have to once more make reference to units who are proudly ready to take part and respond under the command of the Puerto Rican State Guard. I also have to mention my hometown, a small town called Guayanilla, who's honorable Mayor Ceferino Pacheco Giudicelli, also a Vietnam veteran, with enthusiastic spirit collected funds to raise up a monument to the American military man. He didn't do it just for the hometown. He didn't do it for the Puerto Rican alone, but for everyone.

I have to recall a very sentimental poem written by Professor Raul Crespo Nieves, who dearly expressed his feelings about a street named after a young soldier. And he says the people today have forgotten about him. They don't know who he was. They could care less who he was.

The school where I graduated bear the name of a fallen son who became a casualty during the second world war. Today the school is still there. It may not look too much like it was yesteryears, but still erected there. I hope it is there every time I go back to visit my hometown or return to Puerto Rico to live in the future. I live now in New Jersey and go back and forth.

And to me it has been a pleasure, very satisfying to address you. For allowing me to talk, thank you a lot, and may God bless you.

[The prepared statement of Mr. Torres-Gonzalez appears at p. 87.]

Mr. EVANS. Thank you for your testimony. Tony.

STATEMENT OF LOUIS ANTHONY "TONY" SANTILLANES

Mr. SANTILLANES. Thank you, Mr. Chairman.

Mr. Chairman and members of the committee, I am Luis Anthony Santillanes and I am here because I am a Hispanic businessman and also because I have been the Chief Executive Officer for the American Legion for the last 13 years.

Incidentally, I was a Navy corpsman with the Marines in Korea where I served with plenty of Puerto Ricans also, and I was the interpreter part of the time when we served there.

I am also here probably because of things that this Veterans Affairs Committee has done when they approved the GI Bill. I am a product of the GI Bill. I came back from Korea, which gave me the opportunity to go to school and get my degree in the funeral service.

But the Hispanic veteran in the State of New Mexico goes back to the 1500s when the conquistadores came in. The contribution of the Hispanics began at that time. Although they were called conquerors, they were anything but that. They brought the cattle and the horses, the sheep into the area. Instead of killing the Indians, they intermixed with them and intermarried and taught them to raise livestock, to farm, and introduced them into the Catholic religion. To this day, the Native American and Hispanic beliefs are intermixed when you go to services.

They established the first seat of government in the United States, and Santa Fe is still the seat of government and is the longest continuous seat of government in the Nation, having been established in the 1500s.

Hispanics in New Mexico have been involved in and been a part of every conflict the United States has been involved in since then. There were Hispanics in the Civil War. They were involved with General Pershing in invading Mexico when Pancho Villa invaded Columbus. They were part of Teddy Roosevelt's Rough Riders.

Hispanics were trading goods with Spain before the pilgrims landed at Plymouth Rock. In World War I the majority of the soldiers that went to Europe from New Mexico were Hispanic. They returned to New Mexico, continued the ranches, farms and other enterprises in New Mexico.

When World War II came along the National Guard in New Mexico was already in the Philippines. The majority of the troops were Hispanic. They were the ones who defended Corregidor and a major part of them were in the Bataan "death march."

During World War II the per capita of Hispanics joining the Service from New Mexico was rated number two in the Nation following the State of Texas, who was one in per capita. When the Korean War came along New Mexico rose in per capita to be number one in the Nation of Hispanics in the military service of our country.

The Vietnam Conflict produced the largest percentage of Hispanic veterans from the State of New Mexico, and the largest majority of Hispanics who went into the military service. The National Guard and all the servicemen from New Mexico involved in Grenada and Desert Storm again were for the major part Hispanics.

One of the major reasons for that is the Hispanics were the majority in New Mexico till the early sixties, and the Hispanics ran the majority of the legislatures, and the elected officials in the State of New Mexico were Hispanics. So, we didn't have quite a bit a lot of the problems we had in some other places with the Hispanic because the Hispanics were in charge.

But they were responsible for most of the progress we made in the State up to that point, the late 1950s, early 1960s. But the turning point of the Hispanics in the State of New Mexico and the Hispanic population was the introduction of the Hispanics from all over the State being forced to use the English language when they were still using the Spanish language, and the passage by this Congress of the GI Bill of rights that allowed the Hispanic veteran to get higher education. We in New Mexico gained many Hispanic teachers qualified to teach our children. We also gained many other professionals.

The Hispanic veteran was able to buy homes under the GI Bill. They can also get business loans, and in that way were able to make the bigger and better contributions to development of the State of New Mexico.

The State of New Mexico and the Nation owe a great deal to the Hispanic veteran for the numerous contributions that the Hispanic has made and continues to make. Now more than ever the Hispanic veteran is involved in the political arena. The Lieutenant Governor of the State this year Casimiro (Casey) Luna, a successful businessman, he credits the GI Bill for much of his success.

The former Chairman of the Veterans Service Commission for the State of New Mexico is a Vietnam veteran who also credits the GI Bill for his law degree and his success.

The list is endless of Hispanics who have contributed to the development and progress of New Mexico. But I feel that a lot of the credit must go to this Congress for passing the GI Bill as it was presented by The American Legion. They had the foresight to see that if it was good for the Nation and it was good for the veteran it was good for everyone.

The money returned to the Treasury through taxes from higher income derived from better jobs, that came as a result of higher education and vocational training. Farmers, cattlemen, shopkeepers, and all segments of the population were aided by the education and loan guarantees provided by this momentous legislation.

We must never forget the contribution made by the Hispanics and the other veterans in this country, and we must continue and this Veterans Affairs Committee must continue to aid the new veteran being discharged now by providing him or her the same opportunities for higher education, vocational training, job procurement assistance and loan guarantees.

Thank you very much.

[The prepared statement of Mr. Santillanes appears at p. 93.]

Mr. EVANS. Thank you very much.

I want to, as a Vietnam era veteran, welcome these two Korean War veterans to our committee today. I think it has, you know, been a war that some Ivy League historians call the "forgotten war." Well, it has not been forgotten by the people who fought it or their families that suffered through it, and we very much appre-

ciate your contributions at places like the Frozen Chosen and the Freezing Season, as I guess they called it, a part of the other battles at Pork Chop Hill, a part of our heritage and our legacy. We salute you for that most difficult war that you fought very strongly.

I am also a beneficiary of the GI Bill program. I doubt that I would be sitting here as a Member of Congress had it not been for the GI Bill allowing me to go to community college and college in my hometown and law school. So, I am a strong supporter.

One of my concerns is that a lot of people who have gone into the military, and not all of them, perhaps as much as ten percent when they joined the military recently have not signed up for the GI Bill. I would assume many of the people who did not sign up, from my own observation at one class where they were being introduced to the GI Bill and asked if they wanted to participate, I suspect that the majority of those that declined the GI Bill probably were minority servicemen and women.

Now, as the military is being downsized, I think that particularly will have an impact on those people who had intended to make the military a career. There are other issues dealing with downsizing, but I think that is one.

Are there other Hispanic veterans who you can identify that are having difficulties because they are being separated from Armed Forces before they had expected to be?

Mr. SANTILLANES. Well, the one thing, Mr. Chairman, is that right now the amount of money that the veteran gets to go to school does not compare with what the World War II veteran got and the Korean War veteran got. You know, we would get so much a month but it would handle our expenses.

Three hundred to four hundred dollars a month does not handle expenses. It does not even pay the school now when you are paying \$700 to \$7,000 in tuition. So, this is a big problem that the Hispanic and all veterans have in going to school under the GI Bill. That there is not enough money to pay the tuition.

We have to make it equitable to what it was after Korea and after World War II.

Mr. EVANS. Good point.

Mr. Torres-Gonzalez, any remarks?

Mr. TORRES-GONZALEZ. No. I am very pleased at being here, once more. And, as I say to you, just like in the Ben Hur history when the commander's ship of the naval fleet was sunk and Ben Hur saved his life, he said to him, "Row well so that we can keep the boat afloat." And read my book "The Advisor Da Covan."

Mr. EVANS. We appreciate it.

Mr. SANTILLANES. Well, the only thing I have to say is I want to thank you for having me here, and I hope that this becomes an annual thing that the Hispanic can get some of the things that were brought up before on the needs of the Hispanic, but also on the benefits the Hispanics has gotten, so that we all know the contributions and the needs of the Hispanics in this committee.

Thank you very much.

Mr. EVANS. We have a few other, perhaps, questions from my colleagues.

I do want to note that my colleagues on this committee have asked me to make this an annual hearing and an opening of the

door in the process, and I have committed to do that. We appreciate your leadership.

The gentleman from Illinois?

Mr. GUTIERREZ. Thank you, Mr. Chairman.

I would just like to make a comment. First, Mr. Gonzalez, it was wonderful listening to you today. I am very happy that you took the time to come from New Jersey and spend some time with us here today. Thank you.

And to Mr. Santillanes, Tony, I would like to say it is good to hear about what people are doing and what they are doing with their lives, and we hope to hear, obviously, more today. I was very interested in hearing how you served, and about the GI Bill, and see how we take that bill and other bills and help improve them.

So, to both of you thank you so much for being here this morning. It has really been a pleasure and informative.

Mr. EVANS. The gentleman from Texas.

Mr. TEJEDA. No questions, Mr. Chairman. I just also want to thank Mr. Santillanes and Mr. Gonzalez for being here. I know they come from far off places, so thank you for your effort and thank you for your testimony.

Thank you very much.

Mr. EVANS. The gentleman from Puerto Rico.

Mr. ROMERO-BARCELO. Thank you, Mr. Chairman.

I also want to thank Mr. Santillanes and Mr. Torres-Gonzalez for being here today and having taken their time. The history, additional history you gave us of the 65th, which I know is one of the infantry regiments in Puerto Rico, the pride of the people of Puerto Rico, particularly those who served and the families of those that served. I commend you for it.

Thank you.

Mr. EVANS. Thank you.

We salute your service, appreciate your testimony, and look forward to working with you in the future. Thank you for testifying.

Mr. EVANS. The members of our second panel are Tino Zamora, Jose Luis Martinez, Agapito Rivera and Andrew Rodriguez. Tino is National Program Director, American Association of University Affiliated Programs for Persons with Developmental Disabilities. Mr. Martinez is a Veterans Readjustment Counselor in Chicago, IL. Agapito Rivera is a Veterans Outreach Specialist with the Puerto Rican Veterans Association of Massachusetts, in Springfield, MA. Andrew is a Disabled Veterans Outreach Program Labor Service Representative with the New York Department of Labor in New York, NY.

Tino, we will proceed with you once you are situated.

STATEMENTS OF TINO ZAMORA, NATIONAL PROGRAM DIRECTOR, AMERICAN ASSOCIATION OF UNIVERSITY AFFILIATED PROGRAMS FOR PERSONS WITH DEVELOPMENTAL DISABILITIES, SILVER SPRING, MD; JOSE LUIS MARTINEZ, VETERANS READJUSTMENT COUNSELOR, VETERANS RESOURCE CENTER, CHICAGO, IL; AGAPITO RIVERA, VETERANS OUTREACH SPECIALIST, PUERTO RICAN VETERAN'S ASSOCIATION OF MASSACHUSETTS, INC., SPRINGFIELD, MA; AND ANDREW RODRIGUEZ, DVOP/LABOR SERVICES REPRESENTATIVE, NEW YORK DEPARTMENT OF LABOR, NEW YORK, NY

STATEMENT OF TINO ZAMORA

Mr. ZAMORA. Chairman Evans and members of the House Veterans Subcommittee, thank you for inviting me to present testimony here today on the topics of Hispanic veterans' contributions to the Nation and community, receipt of Federal veterans benefits and related issues.

My name is Tino Zamora. I am a Vietnam veteran and a Hispanic American. I come from a family with a long tradition of service to our country. My grandfather served in World War I, my stepfather in the Korean, and several of my younger brothers also served in the military.

One brother has decided to make the military his career. He is currently in the Army.

My mother is a veteran's dependent under VA law and benefits since my stepfather was a totally disabled veteran and has since died of service-connected injuries.

I mention my family because they have always been one of the most important influences in my life. I mention my family because I feel strongly that families are a key factor in addressing the needs of Hispanic populations, especially veteran populations.

My testimony here today will hopefully elaborate my position and offer a challenge to those people interested in reaching and serving Hispanic veterans communities. My background and experience dealing with veterans is both personal and professional.

I have worked with and for the veterans community for well over 25 years. I am currently a National Project Director for the American Association of University Affiliated Programs for Persons with Developmental Disabilities here in Washington, DC.

I specifically administer a training and technical assistance program targeted at Vietnam veterans, their families and their children with developmental disability. The program I administer is funded by the Agent Orange Class Assistance Program. Its name is AOCAP. I know that chairman Evans is familiar with the AOCAP. However, other members of the committee may not, so I have attached a brief description of our purpose and our mission.

In the past 25 years, I have had the unique opportunity and pleasure of serving the Vietnam veterans community, but it was not until recently that I realized that we were not truly meeting the entire needs of the veteran. It wasn't until I began working directly with the families of Vietnam veterans that I understood the benefits and the rewards of family-centered and family-focused approaches to helping in reaching the veteran.

We had neglected a crucial part of the veteran's life, Mr. Chairman—his family.

In the past, our programs focused entirely on the veteran. For example, most traditional veteran programs target the veteran and his or her problem. The family is secondary to any solution. In my own professional case, whenever a veteran came into our office with his family we would bring the veteran in for assistance while the family sat in the waiting room. It never occurred to us to invite or include the family in the discussions.

What I now realize is that especially for Hispanic veterans the family is central to any solution and can play a significant role in the process. Recent studies dealing with Hispanic populations and culture have shown that family involvement and identification are key characteristics of the Hispanic culture.

It would seem obvious to anyone to target this group when working with this population. Mr. Chairman, I would venture to say that traditional approaches still do not see family as key to addressing the needs of individual veterans.

The challenge is for traditional service providers like the VA to be more inclusive of family in dealing with veterans. I know that some of my colleagues here today will testify as to the shortcomings of the VA in outreach and servicing Hispanic veterans. I would echo their concerns but would recommend to this committee that legislation be initiated immediately that defines families as part of the veterans community and eligible for certain services and programs along with the veteran himself or herself.

I am sure the VA would debate the fact they serve families today. But we all know VA law, and it states they provide benefits and services to dependents. Dependents do not necessarily equate to family, Mr. Chairman. Most family members are not qualified as dependents under VA law and would not be currently eligible for services.

I would argue that without addressing the entire family in the context of the veteran and his and her problems is defeating the purpose of the help. Any effective strategy begins with a plan, a plan that thoroughly looks at the targeted audience. We need a survey or other research to define the problems of Hispanic veterans and their families as it relates to services and needs.

At the same time VA should implement cultural awareness training regarding both general and specific facts about the Hispanic culture. The use of existing successful multi-cultural programs like those used by the University Affiliated Programs which I work for should be investigated and implemented. I am sure UAPs throughout this country would be interested in sharing their expertise in this area.

Developing cultural competencies which acknowledge differences between people and cultures while at the same time developing effective programs for veterans and their families is paramount to any successful approach taken. I would highly recommend to the VA to utilize existing programs like the AOCAP that I mentioned earlier at the community-based level to reach and address the veteran through family-centered and family-focused programs. Why reinvent the wheel when you already have designs in operation?

AOCAP projects could work in concert with VA programs to immediately address family and children issues. This would allow both programs to leverage resources at a time when resources are limited and/or scarce.

Mr. Chairman, the members of the Hispanic Veterans Network, a coalition of programs and individuals working with Hispanic veteran populations, is available to help develop a plan for addressing the needs and issues of Hispanic veterans.

We thank all the members of the committee for the opportunity to present our concerns and recommendations. I personally appreciate the opportunity to be heard. Once again, I thank you for inviting me to this hearing.

[The prepared statement of Mr. Zamora, with attachment, appears at p. 98.]

Mr. EVANS. Thank you very much. Mr. Martinez.

STATEMENT OF JOSE LUIS MARTINEZ

Mr. Jose Luis MARTINEZ. Mr. Chairman and members of the subcommittee, other speakers and guestS, good morning and thank you for the opportunity to appear before you and express my personal views and observations for outreach and service to the Hispanic veteran.

My name is Jose Luis Martinez. I am a Readjustment Counseling Technician at the Veterans Resource Center in Chicago. One aspect of my job is to conduct outreach to the veteran community. During the past year I have concentrated my outreach efforts to the Latino community in an effort to reach Latino veterans and their families.

I have had limited success. One of the factors is the size of the Latino community in Chicago. The problem still remains that awareness of VA benefits and programs is very low within the community, and greater efforts are required if we are to effectively serve this segment of society.

Sir, I am still only one of three Latino counselors in the region. It is my view that Latino staff are still far too few in numbers to effectively outreach the many Latino communities. Cities like Milwaukee, Minneapolis, Kansas City and St. Louis could particularly benefit from the hiring of Latino staff at Vet Centers. Counselors and social workers need to reach Latino veterans with shared cultural values.

The Latino veteran must be approached with understanding of and sensitivity to his culture. The fact that a counselor or social worker can approach a veteran with a shared sense of culture and/or ethnic value can make a difference in whether he can gain the veteran's trust and is therefore able to help him.

The obvious solution to outreach would be to hire more Latinos. However, that is not enough. A training program of cultural sensitivity should be implemented and maintained. This program must deal with issues affecting the Hispanic community, special needs of Latino veterans, both male and female, and issues and norms unique to Latinos. This leads to the area of opportunity within the Department of Veterans Affairs and other government agencies. On this subject, I can only speak from personal experience.

I began a civil service career in 1974 with the Federal Aviation Administration as an air traffic control specialist, a position I lost

after participating in a job strike. During the next 7 years I made numerous applications with other Federal agencies without success, until 1988 when I was hired as a seasonal examining clerk by the IRS. Two seasons later I resigned that position in protest because of unfair treatment to elderly and poor taxpayers.

I began my campaign for employment with the Department of Veterans Affairs in January 1990 for the St. Louis Medical Center. I applied for all positions advertised for which I could qualify without success, until August 1991 when I was appointed to a temporary position within the St. Louis Vet Center as an outreach specialist charged with initiating and maintaining an outreach program to returning Operation Desert Storm vets. I remained in that position as a volunteer until December 1992, when I was notified that I had been selected for my present position.

Sir, I met the requirements on all positions for which I applied, but was interviewed only once and that only after an informal inquiry on my lack of success. On one occasion the published experience requirements were changed after the closing date of the announcement, effectively eliminating me from consideration.

On another occasion I was offered a position as a food service worker, basically a dishwasher, after talking informally with an EEO representative. I had applied for a position in food service management.

I inquired about veterans preference and clarifications on hiring practices. I was informed that the only positions within the Medical Center set aside for veterans were the food service worker position at the lowest level, which is a dishwasher, and a housekeeping aide, which is a janitor. I cannot prove that my ethnicity or my background were eliminating factors, but the fact remains that I was not able to secure a position with the St. Louis Medical Center.

I applied for employment in other geographical areas and with other agencies, on several occasions I later found out that the person hired was nonveteran, non-minority. On one position, in Greensboro, the selecting official informed me during a telephone conversation, after he had assured me that I was going to get the job, that the hospital personnel department administrator had forced him to hire the nonveteran because he was already in the hospital system, even though her qualifications were no greater than mine.

There appears to be a faction within the personnel offices of the VA Medical Center that handicaps veterans applying for employment, and being a Vietnam veteran is the equivalent of having an albatross around your neck. A new direction is needed in assuring veterans preference within the VA and in designating more positions for veteran applicants only.

Utilization of the Veterans Readjustment Act provisions must become a priority. Greater attention and closer supervision and monitoring of personnel officers is needed to ensure veteran preference programs and directives are being followed.

Even when the obstacles of employment are reduced or eliminated and a greater number of Latinos can be hired to service the Hispanic community, then a greater number of Latinos can begin to utilize the VA facilities. This can reduce the negative incidence experience when seeking medical services in the VA hospitals.

I have two examples of these negative incidents. The first one is Mr. Sanchez, a Puerto Rican veteran who sought help at a local VA hospital in Chicago. He is a recovering addict and a homeless vet. He had recently returned from Puerto Rico thinking he had greater opportunity of receiving SSI in Illinois because it was not available in Puerto Rico.

Mr. Sanchez has an extensive medical history, including three open heart surgeries and a brain aneurysm. He spent numerous hours in the emergency room feeling neglected and ignored because when he was in the emergency room they took his clothing. He was released in the early morning hours without help or medication, either methadone or heart medication. He spent several days on the street after that release until participating in a weekend stand down for homeless veterans where he got some services and some promises only after he talked to the Secretary of Veterans Affairs.

Mr. Sanchez was going through withdrawal from methadone during that stand down and suffered severe seizures for which he had to be hospitalized. He was just released from Hines VA Medical Center where again he had severe seizures that now our doctors are investigating and believe are related to the aneurysm, but could be related to the methadone.

The second case is that of Elda Martinez, who happens to be my sister and a veteran. She has a case history of cardiovascular and glandular problems. She sought help at the same Medical Center because of severe chest pain. She had recently relocated from San Antonio where she had received excellent treatment at the Audie Murphy Hospital.

Elda is medically retired, having worked as a social worker for over 20 years with the Texas Department of Human Services. She is on a very limited income, and the VA hospital system is the only viable option for health care.

On an initial visit, she was kept waiting in excess of 6 hours and was still in the lobby when the clinic was closed and the doctors left for the day. She was interviewed by a nurse on a subsequent visit and was told she was not sick enough, and given a bottle of Maalox for her symptoms. She later sought service at Loyola Medical Center in Maywood. Luckily for her the examining physician also practiced at Hines VA Hospital and recommended that she go there and become admitted. She was admitted, a verified mild heart attack. She spent a little over 2 weeks at Hines Hospital, was scheduled for angioplasty procedures, which were performed at a later date.

Now, these cases are not unique but indicators of what is happening to Latinos and other minority veterans within the system.

As Latinos our English is accented. We sound different, and we encounter the problem that others listen to our accent and not to what we are saying.

Another issue, of course, is that of status. Latinos as a major ethnic minority, are second only to the American Indian in historical priority, having been in parts of this Nation even before the ethnic majority arrived on these shores. At the same time, with recent arrivals from Cuba, Mexico, and other Latin American countries, we are the most recent immigrant group. This puts us in a curious

paradox. We are such an old group that we have been forgotten and such a new one we are just now being discovered.

Focus groups need to be formed to identify needs within the community and recommend plans of action to alleviate these needs. One such group, the National Hispanic Working Group for Readjustment Counseling Service, present here today, is very active in this area. I expect with the support of the Minority Affairs Office in the VA and this subcommittee that they will have tremendous impact on the Vet Center program and the VA in general.

Outreach needs to be coordinated to ensure coverage of the whole community without duplicating efforts. Outreach efforts need to be expanded to community-based and social organizations, getting them involved in recruiting and/or recommending candidates for services or employment.

A recruitment program needs to be implemented to target Latino students in colleges and universities utilizing the outstanding scholars program. Professors, counselors and school administrators need to be recruited to identify qualifying students.

A program of involvement in public and private elementary and high schools within the Latino community should be implemented to identify children of veterans and have presentations on services, programs, and careers tailored to them.

Thank you very much.

[The prepared statement of Mr. Martinez appears at p. 107.]

Mr. EVANS. Thank you, Mr. Martinez.

Mr. Rodriguez.

STATEMENT OF ANDREW RODRIGUEZ

Mr. RODRIGUEZ. Good morning, Mr. Chairman. My name is Andrew Rodriguez, and I work with the New York State Department of Labor as a Labor Services Representative (disabled veterans outreach). I am known as a Disabled Veterans Outreach Program Specialist, or DVOP. From 1968 to 1969 I have served as a weapons specialist in a Marine Corps unit in the Republic of Vietnam. I was wounded and received the Purple Heart for that wound.

I wish to extend my thanks—our thanks and congratulations to you and the Committee of Veterans Affairs for holding this hearing to focus our attention on "Hispanic Veterans: Veterans Readjustment Benefits and Related Issues."

The Disabled Veterans Outreach Program is described in section 4102(a)(b) 95(a)(1) of Title 38. Funding is intended to be made available to each State sufficient to support the appointment of one DVOP for each 6,900 veterans residing in such States, who are recently separated, Vietnam era or disabled veterans. Preference in appointments is given to qualified veterans, disabled veterans of the Vietnam era.

The role of a disabled veterans outreach person is to provide maximum amount of service with emphasis on job placements, and to ensure that the needs of other economically and educationally disadvantaged veterans are addressed.

The DVOPs in each State are stationed in local Veterans Employment Offices and at least 25 percent are outstationed in Veteran Outreach Centers of the U.S. Department of Veterans Affairs and other appropriate sites.

Each DVOP provides services to veterans, develops job and training opportunities through contacts made with employers, especially small and medium size sectors, and performs other functions within the parameters allowed by law.

I have served for 13 years as a disabled veterans outreach person based out of the New York State Department of Labor, West 54th street Community Service Center in Manhattan. This facility is one of the largest in the Nation and serves as many individuals as some of the smaller States.

Many veterans I serve at this location are of Hispanic-American and African-American heritage. I provide them with a wide range of services out of our VET TAC unit. The VET TAC unit is the Veterans Testing and Advisement Center. It was established in 1990 to provide counseling and vocational guidance to veterans. In addition to providing testing and referral and placement services we are considered a New York State regionwide resource for more specialized services.

In 1988, Governor Cuomo established the Veterans Bill of Rights for Veterans Employment at the New York State Department of Labor. An essential element of this initiative is the Veterans Hotline, employment hotline, which was set up to provide veterans from all parts of New York State with information on employment training and that will lead to further employment, where and how to access information and obtaining Federal and State benefits. In short, we provide a myriad of services all designed to place veterans in meaningful jobs.

While veterans anywhere in the United States have certain rights to priority service pursuant to provisions of Title 38, chapters 41, 42 and 43 of the United States Code, the average veteran is often unaware of the rights he or she may have under this law. The New York State Veterans Bill of Rights is based on the premise that every veteran should be informed of his or her rights in a clear, concise manner and be provided with a simple but effective means of redress if those rights have been abridged.

Those five rights are:

(1) to ensure that veterans are treated with courtesy and respect at all New York State DOL facilities.

(2) to give priority in referral to jobs to qualified veterans and eligible persons.

(3) to give priority in referral to training to qualified veterans and eligible persons.

(4) to give preferential treatment to special disabled veterans in the provision of all needed local office services.

(5) to provide information and effective referral assistance to veterans and eligible persons regarding needed benefits and services that may be obtained through other agencies.

These are posted in several locations in the New York State Department of Labor, including in the waiting area. Each man and woman who comes to us for service is asked, "Did you serve on active duty in the United States military?" If the answer is yes, the person is provided with a wallet-size card which lists their rights as well as other information, and lists the toll-free numbers.

At least 16 States have followed New York's lead of the Veterans Bill of Rights for Employment in one form or another, based on

Governor Cuomo's model. Such States such as Michigan and Ohio have done this by enacting State law. Others such as Mississippi, New Jersey, Connecticut, California, West Virginia and Florida have done so by administrative action and executive order by the Governor.

While New York accomplished implementation of the original veterans bill of rights employment service modeled by administrative objections, those actions are affirmed and expanded with enactment of chapter 553 of the laws of New York City on July 26, 1994, which extends preference to veterans in all Federally-funded employment and training and remediation programs operated by and through New York State government entities. A copy of this legislation and the approval message of Governor Cuomo is attached (appendix II).

The purpose of this hearing is to determine the impact the activity has on Hispanic-American veterans and their need for services to assist them in successfully readjusting to American society. In response, we believe that the ability to obtain and sustain meaningful employment at a decent living wage is the crux of the readjustment process.

According to the United States Veterans Affairs Analysis and Statistical Service, there are over 75,000 veterans of Hispanic-American origin in New York State. That number represents the third largest Hispanic-American veteran population in the Nation, behind California and Texas, and the largest of Puerto Rican heritage.

The median income of Hispanic-American veterans equals only about 80 percent of their white counterparts. Hispanic veterans have much lower labor market participation than white veterans. The greatest disparity is among Hispanic-American veterans of the Vietnam era. This disparity in objective measurement of economic well-being of Hispanic-American veterans versus their white counterparts is one that is longstanding in nature and has not lessened appreciably over the last 20 years.

The connection between readjustment problems due to military service and employment as a reflection of successful readjustment can be best seen by comparing statistics from the National Vietnam Veterans Readjustment Study results issued in July of 1988 still supported by the PTS study of the VA dated April 29 of 1994. With the unemployment rate of Vietnam era veterans issued at the same time by the Bureau of Labor Statistics. That is in appendix III. Please find.

The prevalence rate among Hispanic Vietnam Theater veterans related by ethnic group of unemployment from surveys conducted at the same time. Most alarming is the prevalence rate of PTSD Hispanic theater veterans, which is at 27 percent, which exceeds that of black theater veterans of 19 percent and white Vietnam Theater veterans of 14 percent.

You will note that the pattern is the same for both studies, suggesting the correlation between significant readjustment studies and the ability to sustain meaningful employment. This is particularly significant given that the increased population of the United States military forces are Hispanic-American and other minorities. Large numbers of these men and women served in the combat

arena and are most likely to be exposed to situations that can lead to significant post-service readjustment problems, including PTSD.

We must focus on steps Congress and others can take to address and hopefully reverse this disparity in the ability of Hispanic-Americans to secure vitally needed services that will enable them to obtain and sustain meaningful employment, strengthening the fabric of our economic life and our communities.

Thank you, Mr. Chairman, for the opportunity to present these observations and suggestions to you and your committee today.

On behalf of the honorable John F. Hudacs, Commissioner of the Department of Labor of New York State and my colleagues, I thank you for your leadership in holding these hearings.

[The prepared statement of Mr. Rodriguez, with attachments, appears at p. 111.]

Mr. EVANS. Thank you, Mr. Rodriguez.

Mr. Rivera.

STATEMENT OF AGAPITO RIVERA

Mr. RIVERA. Buenos diaz. Mr. Chairman and members of the Committee on Veterans Affairs, my name is Agapito Rivera. I am an Outreach Specialist and retired first sergeant from the U.S. Marine Corps. I work at the Puerto Rican Veterans Association of Massachusetts, and we welcome the opportunity to share experiences within the Hispanic veterans community on homelessness.

As one of nine Veterans Outreach Centers in the Commonwealth of Massachusetts, we are the only Hispanic Veteran Outreach Center in the State of Massachusetts that operates to provide services to those who have served and have answered the call of duty to this grateful Nation in the time of need.

About 90 percent of all the veterans we service are of Puerto Rican ethnic background. We are serving veterans from World War I all the way through the Persian Gulf era. We worked many different cases, one of the areas that we work in is homelessness. We work to provide services to the veteran for compensation and pension, discharge upgrading, counseling, Agent Orange, small business loans, obtaining VA home loans, employment and training. These are just a few to mention.

The picture that is provided on the actual cases on Hispanic homeless veterans is really unclear at this time, and this is basically due to our culture.

One of the things we take into consideration because of our culture, the majority of the Hispanic or Puerto Rican homeless veterans will normally be sheltered by their families and therefore, do not get a true picture on the number of Puerto Rican homeless veterans.

Our families, on average, will be placing themselves in harm's way by providing the homeless veteran with a roof over their heads, especially when that family is receiving assistance from any type of program.

In general, the homeless population in this Nation is unsatisfactory. Granted we have veterans who do not have luxury of being sheltered by family members. We know the majority of veterans within the homeless population are Afro-American and Hispanics,

and accounts for about approximately 40 percent nationwide. A lot of it has been created by drugs and alcohol.

Another point to mention is that the majority of these homeless veterans receive a less favorable type of discharge from the Armed Forces. One special group of veterans is the Vietnam War veterans where these veterans provided valuable services in combat operations in Southeast Asia. Many articles have been published that this group of veterans make up the greatest population within the homeless community.

One of the reasons these veterans are homeless is that when they returned from Vietnam they received bad paper; i.e., bad conduct discharge, undesirable discharge, et cetera. A lot of it was due to post traumatic stress disorder (PTSD), drugs, alcohol dependency, and AWOL, because they could not cope with life once they returned from combat.

The Armed Forces never considered the sacrifices that these veterans made for this country. Many Vietnam War veterans are highly decorated war veterans that were willing to give up their lives for this country.

Congresswoman Maxine Waters from California has proposed that consideration be given to this group of veterans to upgrade their discharge characterization so they could receive the benefits they rightfully deserve. We believe this will have an impact in reducing the percentage of homeless veterans.

There is so much more that could be done. However, this is only a small steppingstone to curtail the homeless population within this grateful Nation of ours.

In closing, I will state that there is a tremendous need for a culturally sensitive outreach program to the Hispanic veteran community. The Department of Veterans Affairs must also increase their bilingual staff to provide assistance to Hispanic veterans that have a language deficiency that exists in this Nation. Many Puerto Rican veterans relocating to the United States have and will continue to have this problem for many years to come. This is why it is imperative that a coalition be set up to help these veterans. This program should be funded at the Federal level with offices nationwide.

Again, on behalf of the Puerto Rican Veterans Association we thank you and this committee for giving us the opportunity to address you. Thank you.

[The prepared statement of Mr. Rivera appears at p. 125.]

Mr. EVANS. Thank you, Mr. Rivera.

I will address some specific questions to individuals, but if anybody else wants to respond, please do so. Starting with Mr. Rivera, in your opinion what percentage of Hispanic veterans you serve do not receive VA benefits and services because of the language barrier?

Mr. RIVERA. Well, sir, we have seen many Puerto Ricans relocate to Massachusetts to obtain services. They have not been able to successfully open a claim through the VA system. These veterans were referred by other members that relocated to P.R. We have opened claims successfully for this veterans.

We don't know what the problem is in Puerto Rico with the VA system down there. However, the VA systems, I guess, depending on different localities will work in different ways.

As I stated before, we are the only Hispanics Veterans Outreach Center operating in Massachusetts. We are providing veteran services to many different localities within the State. The Puerto Rican veteran that relocates to the U.S. has a language deficiency. When these veterans try to obtain services from a Vet Center, and can't communicate, they are simply turned-off. We feel these veterans have the same right to the services provided just as any other veteran. This is why it is imperative that Vet Centers have bilingual capabilities.

Mr. EVANS. Is language not the only factor? Could location of a Vet Center in a different part of town from where a veteran lives affect his participation in that program?

Mr. RIVERA. Well, sir, being in Springfield, the western part of the State, that we do have, many different centers/agencies will refer the Hispanic Veteran to us, so that we can provide the services they are pursuing.

I will give you an example. Vet Centers in Massachusetts will call on us in particular to say I have a Hispanic veteran here. We don't know what he wants. Can you help him out?

Sure. Send him down and we will take care of him.

Mr. EVANS. One final question to you, Mr. Rivera. I would assume that the vast majority of Hispanic veterans receiving bad paper discharges are from the Vietnam era?

Mr. RIVERA. Yes, sir. After going through the files we have, the vast population of these veterans who got bad paper, are actually combat veterans from Vietnam. These veterans fought and came back and due to some odd reason, when they came back home, they could not cope with the life back home, they received bad paper because they started either smoking marijuana, utilizing drugs.

Like I said, a lot of things were not taken into consideration. Here we have a highly decorated veteran and then all of a sudden he receives a bad discharge and he goes down the drain.

I would just like to quote something. A couple of weeks ago I went to a homeless veteran summit, and something was mentioned from one of the individuals: Here we have a veteran that has fought for our country and has been highly decorated, and all of a sudden he does something wrong, he gets a bad piece of paper. Here we have an individual in the States who commits murder and goes into prison and he comes out, he is rehabilitated, and this individual can actually go out there and find better employment than that veteran can.

Mr. EVANS. I might add that people got bad paper discharges for things that weren't really crimes in civilian society. Not trying to condone or excuse what they might have done, but they carry that bad record for the rest of their lives.

Mr. RIVERA. That is correct, sir.

Mr. EVANS. Do you or Mr. Martinez know the percentage of the Hispanic veterans that you are dealing with who have bad paper?

Mr. RIVERA. I do not. All I can tell you, sir, is that right now the amount of veterans that we service is 90 percent Hispanics that

are active members, and the rest, of course, are Hispanic—I mean Afro-Americans, Caucasians, and so on.

Mr. EVANS. Let me shift this to the rest of the panel and see if they have any comments.

Are we seeing a pattern of downsizing, particularly Hispanic veterans being downsized more relative to their percentage of the population of the armed services now? In other words, is this downsizing disproportionately impacting Hispanic veterans?

Mr. RODRIGUEZ. Well, if I may, Mr. Chairman, Latinos traditionally don't like to use the VA. They do as a last resort, but they don't want to go into it and be degraded by the VA system or any institution. Nor does anyone else, really.

But it is outreach to them that needs to be done, correct outreach into the Latino community, and that might help by target marketing, Hispanic media presentations and hiring more veterans. Veterans are always in the forefront of helping veterans. We at the Department of Labor in New York translate our material into Spanish and put it into the Latino community so that they know they have some place to come to and contact us, that we can speak to, be it the veteran or another family member who might be eligible for benefits also.

Mr. Jose Luis MARTINEZ. I don't have any figures on how it is affecting any particular ethnic group, only the individuals that come to the Vet Center. And again, representation of Hispanics at the Vet Center, at my particular Vet Center right now is less than 1 percent.

Of course, that corresponds with 5 percent of the total force in Vietnam, which accounted for 12 percent of casualties and 15 percent of the awards for valor. We're just not reaching them.

I have seen several instances and several individuals that were affected by downsizing. In each case it is individuals with 17 or 18 years of service or they are within a month or two of locking into retirement and they're out. One of them, of course, is the son of a former State Director of LULAC in Illinois. We are trying to get him into employment with the State of Illinois.

Another one is my brother, who is now in Austin. He got hit 2 weeks before he was locked in. He was a CW-3 helicopter pilot at Fort Riley, and he was happily flying around one day and the next day he is out.

Mr. EVANS. I appreciate the fact that you are calling for more research and studies of Hispanic veterans in your testimony. That is what we need to accomplish, I think, through the GAO.

The issues addressed by some witnesses today, bad paper discharges, impact of downsizing, hopefully, will be included in the scope of the report that has been requested by our colleague on the Senate side, Senator Hatch. If they are not included, I think that we may have to request that they be included.

So, I thank you all for your valuable testimony.

Let me yield to my colleague from Illinois.

Mr. GUTIERREZ. Thank you very much, Mr. Chairman.

I think that one of the things that we might wish to undertake and discuss after the hearings is just to collect the testimony and the kinds of issues raised and the kind of specific issues raised in different areas and then formulate a request to the General Ac-

counting Office so that they can be responsive not only to the request that has already been made but any information that we might bring together today.

I would just like to quickly say to Mr. Zamora that I agree that we need to integrate the family completely into the process, and we may need to look at how we redefine that. Again, we can look at that in terms of how we do that.

I would like to say hello to Jose Luis Martinez from Chicago. Good seeing you here. I am happy that you took the time out to tell us at times such a personal story. I appreciate that you have come here.

Agapito Rivera, what can I say? You come with a great delegation from Massachusetts here, always on the front line of letting people know what needs to go on, not afraid to take on sometimes the issue which I know is not the most popular in our community, homelessness in our community. A lot of people like to give it, how would you say, lip service. But then it is quite another thing when it is in your backyard and you have to do something about it.

So, to you and to all of the people from Massachusetts who are here today, which I know are many, probably the largest delegation here of people committed to veterans, I would like to especially greet all of them. They are not only just my friends but friends of America, and especially the veterans community.

Andrew Rodriguez, keep up the good work in New York. They need all the help they can get out there. I am going to make sure that Congresswoman Nydia Velazquez and—Congresslady Nydia Velazquez and Congressman Serrano knows about your testimony here.

I would just like to ask one question, Mr. Chairman, of Agapito Rivera. How is your program working in terms of the Department of Veterans Affairs and the former Veterans' Administration? Can you tell us how you are working together or how things are going?

Mr. RIVERA. I am glad you asked that question, this is something that needs to be addressed.

As an outreach center, one of the biggest dilemmas that we face when dealing with any veterans issues, is that we do not have accessibility into the VA system, they are Federal and we are state, and therefore, are not recognized. Anytime we call on behalf of a Hispanic veteran seeking assistance, and tell the VA counselor who we are, the first words they say, your not recognized by the VA.

This is where the problem comes in, especially where the language deficiency exist. There are unorthodox kinds of things that we do in order to obtain information, but we do it, just to help that veteran.

The biggest complaint we have seen from the veterans, is that the veteran is very displeased with the VA on the timeliness it takes to approve a case. Once it goes through the system, it will take many months and now they no longer tell you how many months. They are coming out in days and telling you it will be solved or you will receive an answer within 300 to 600 or 1,000 days, or whatever it be. It gets annoying.

Being of Puerto Rican background, I will tell you that sometimes we Puerto Ricans will sometimes—if something is going to take too long, we just drop it and put it by the wayside, and this is what

we are trying to curtail. Hang in there. Hang in there. We know you deserve the benefits. Let them make the decision. If not, then we will go ahead and appeal it, and so on.

But the biggest problem is the timeliness, in trying to get a case approved or an answer, on that case.

Mr. GUTIERREZ. I just want to reiterate, Mr. Chairman, at this time that every one should know that between two and four o'clock today we are going to have a roundtable discussion where we are all going to be able to get together with people in a little less formal atmosphere and continue to talk about some of these issues. So, folks should keep some specific things in their minds so we can bring those up as we continue during the day.

Thank you, Mr. Chairman.

Mr. EVANS. Thank you.

The gentleman from Texas.

Mr. TEJEDA. Thank you, Mr. Chairman.

And I would also like to again welcome the members of the panel, and I appreciate their service to their country while in the military and also their continuing service to the veterans since leaving the military.

Let me just ask—and I know that there is a lot of marines in the audience and certainly on the panel here. You know, when we were in the Marine Corps, they used to say there are no brown marines, no black marines, no white marines—we are all green marines. I am sure you all remember that, and the chairman and all.

But has that continued, you know, since we have left the service by the VA, by the States or by the different agencies of the Federal Government or by agencies of the State?

And certainly I will give you some time to think about that. But also in speaking of the State, and I notice that Mr. Rodriguez, Andrew Rodriguez is with a State program, I guess New York State, you know. Have the States done enough for the veterans? And also the State legislature and oftentimes the attitude by others was that the veterans are the responsibility of the Federal Government. They served the U.S. Government and that is their responsibility. I know many of the States have taken the initiative and done their part, some more than others.

And one other question that I want you to think about, and also some of the other panels that will come after you, is are the States doing enough for the veterans? Should they?

And is there a list of the different State programs? Perhaps the Department of Veterans Affairs has that. But is there a list of the State programs for veterans? In other words, which are the most veteran friendly States or which States appreciate their veterans more?

You know, Money magazine puts out an annual list of the most friendly cities for business or the best cities to live in, ranked 1 through 10 or 1 through 20. U.S. News and World Report does their annual list of the best colleges in the Nation, the best graduate schools in the Nation.

I wonder if anyone has a list of the best States for veterans or who does the most for veterans.

And also, and I'll take them one at a time, but also what are the—in your opinion, and I know that there are many, but in your

opinion, in five words or less, each one of you, which are the biggest, the greatest, the worst problems faced by veterans, Hispanic veterans today?

And also, and I know I am giving you a lot, but I will start again. Also, if you could speak directly to Jesse Brown, and if he would say "I will grant you your wish," what would you recommend to him to immediately improve the lot of the veteran in general, and the lot of the Hispanic veteran in particular?

So, Mr. Rodriguez, perhaps you can start. I know you are with a State program. Are the States doing enough? Can they do more?

Mr. RODRIGUEZ. They can do more. They can do more. New York State Department of Labor happens to be in the forefront of working with veterans. However, I am in New York City. New York City has a great population now. Mayor Giuliani works his own thing. Mayor Giuliani does what he has to do to survive. They have an employment service of their own. The targeted jobs tax credit initiatives that come there, they are underutilized by veterans. The JTPA program is not given preferential treatment under the City programs. It has only been that Governor Cuomo just enacted this bill that we hope city programs like New York will pick up on this.

Have the States nationwide done so? I am going to say they are picking up on it very slowly. One thing that you mentioned before that is a problem, PTSD with Latinos. They come back and how do they go back into the community? They are no longer part of the community when they have been trained, disciplined, shown the world. There is a different world outside their neighborhood. There is a real world out there.

Come back into the, hanging out by the bodega is not going to get it any longer. Being on welfare is not going to get it any longer. Job training has to be enhanced. We have to take SMOTA, for instance, and work—the Service Member Occupational Training Act, try to maybe—by the way, we in New York State Department of Labor are encouraging refunding of that, trying to get that intertwined with the Montgomery GI Bill so that therefore those that are coming out and it can be longlasting, not just funding from year to year, they can use it as on-the-job training or use it for educational purposes.

That service member occupational training is brand-new. It is working. It is working in a lot of States really efficiently. Others have to pick up. But we still need a first initiative. We need to refund that also.

Mr. TEJEDA. What would you say to Jesse Brown, perhaps, if he had it within his power to change something immediately, what would you ask him to do?

Mr. RODRIGUEZ. Recognize Latino veterans in the history of the United States.

Mr. TEJEDA. Mr. Martinez.

Mr. Carlos MARTINEZ. On the first question, I don't think anybody is doing enough.

Are there differences between States? Yes, in benefits. Some of them have educational benefits, so some don't. And to varying degrees.

As to things in particular that should be looked at, should be accentuated, is the homelessness program, the employability program—problems, I should say.

There are a lot of VA repo homes and buildings that are being sold on the open market at 40 percent of market value, 30 percent of market value. These buildings or a portion of these buildings could be utilized for transitional housing, and rehab centers, training facilities for veterans and their families. Because a lot of times a veteran is not on the street by himself. He has got his wife. He has got his children.

If I had one thing to ask the Secretary of Veterans Affairs that I could be granted it would be set up a program similar to the CC camps, similar to the Job Corps, specifically for veterans and their families where they could be housed and trained and rehabilitated, and they would come out job ready with job placement assistance.

Once we take care of the concrete basic needs, once he is not hungry, once he is not worried about where his kids are going to sleep or where his wife is going to sleep, a lot of the other problems become manageable. Then he can deal with his PTSD through his counselors, through the PTSD centers, through outpatient therapy, individual and group.

But when he is being overwhelmed by the needs of himself and his family, he can't even think of education. He can't think of PTSD. That is on the back burner.

You know, it goes back to the old saying: How the hell can I drain the swamp when I am up to my ass in alligators?

Mr. TEJEDA. Mr. Zamora?

Mr. ZAMORA. Congressman Tejeda, one of the biggest problems I have heard from veterans themselves and having worked out in the community on the front line is the lack of information that other agencies really have regarding what a veteran is entitled to and what the VA really can offer.

A lot of times those agencies use the VA as a crutch. They kind of say—as soon as you say you are a veteran, they turn around and say the VA will take care of that. And it is kind of like a pass the buck kind of thing.

And it is not that the VA doesn't have some of those things like housing and employment and things of that nature, but there are agencies that have large amounts of funding that should direct that funding to veterans, but they don't. They turn them away immediately, and then the VA gets turned away.

So, if I had something to tell Jesse Brown, I would say—or Secretary Jesse Brown, I would say work with those other Federal agencies, those big agencies. Make sure that they understand that they have to provide services to veterans as well, not just the VA.

And I would say that one of the best things they could do is set up what they had back in the Carter days at the White House. They had what they called an Interagency Coordinating Council out of the White House that dealt with veterans. And it wasn't with third level and fourth level people. It was with the Secretaries and the Assistant Secretaries that they met. And believe me, that was pretty effective.

Mr. TEJEDA. Really that was one of the questions I had asked one of the previous panels also. That many people just automati-

cally assume, and perhaps it is correct, that the primary responsibility is with the Department of Veterans Affairs but that each department whether it is HUD or Labor or Education, they all have a small section on veterans affairs, and you are saying that there is no total coordination at this time?

Mr. ZAMORA. That is absolutely correct.

Mr. TEJEDA. And I believe that is what the panel had said previously also. That there was really no coordination in terms of veterans benefits. I guess it makes it harder for you all on the front lines to let the veterans know where to go or what is available or what information is there.

Mr. ZAMORA. Congressman, I will tell you this. When you do what I call systems change and you change those systems, and they understand what veterans are all about, those systems are prepared to help us. But it is a matter of having the resources to go there and train them on what we need. We don't have those things right now.

Mr. TEJEDA. Thank you very much.

Mr. RIVERA. Yes, sir, Congressman Tejeda. One of the things that—I will start off first about, you asked about employment. I have been in touch with the Department of Employment and Training in Springfield, MA, and presently they have several DVOPs that work with us constantly. But again, one of the biggest things we have is the language barrier.

In regards to the employment arena, one of the things we need is money, more money should be employed into, for example, the Department of Labor to provide additional training for veterans that have lost a job, these additional monies would give the veteran a helping hand to retrain them to do something else. We have found that a lot of cases we review on employment on veterans, especially the Vietnam War veteran has gone through numerous amounts of jobs, one of the causes is PTSD.

We feel if there is some kind of a solid, concrete plan that would be set aside to retrain this individual and see exactly what the needs of that veteran is, then at that time they can work with that individual, and hopefully this will also prevent homelessness, within the veterans population.

One of the things that I would tell Secretary, Mr. Jesse Brown, is that homelessness in this country is uncertain. Mr. Zamora, mentioned to have a panel within the hierarchy, within the U.S. Government to establish an office, basically to have shelters strictly for veterans and target those large cities within the Nation. This of course would provide services to veterans in the areas of, psychiatric treatment, PTSD and drug abuse.

We hope these services will curtail the homelessness population. Once you bring them in, you give them all the treatment they rightfully deserve, and get the individuals employed working through the Department of Employment and Training.

One of the things we need to look at, just like what Mr. Zamora said, not all the big cities have veterans shelters. They do not. In Springfield we don't have one, we have a large population of veterans of all different kinds of ethnic backgrounds.

Something should be set up that will either make funds more easily available, for example, like maybe a center like ours or an

association that would go out there to seek funds to open up some type of shelter of this nature.

We have already tried, and ran up against many brick walls, trying to obtain funds to open up a homeless shelter for veterans. The biggest thing I would say, is to have veterans shelters located nationwide in all major, big cities.

Mr. TEJEDA. Thank you very much, Mr. Chairman.

Mr. EVANS. Thank you.

Mr. GUTIERREZ. Mr. Chairman?

Mr. EVANS. The gentleman from Illinois.

Mr. GUTIERREZ. I am going to leave the hearing right now and respectfully request that I be granted leave to leave here for a moment to go to another meeting. I know that you have put this meeting together and that you will not be able to be at the luncheon, and I want to make sure that I can be back here for the luncheon to represent this committee during the luncheon. And I want to take care of these matters now so that I don't have to be interrupted between two and four o'clock when the roundtable discussion begins.

So, with your permission, Mr. Chairman, I will leave now so that I can come back and fulfill the responsibilities during the afternoon.

Mr. EVANS. We will be well represented.

Mr. GUTIERREZ. Thank you, Mr. Chairman.

Mr. EVANS. Thank you all for this testimony. We appreciate your clear answers to our questions. Thank you.

Our next witness is Dave Burge, the Acting Chief Minority Affairs Officer and Acting Assistant Secretary for Policy and Planning, Department of Veterans Affairs.

Dave, once you are seated and your colleagues join you, we would like you to introduce them.

STATEMENT OF H. DAVID BURGE, ACTING CHIEF MINORITY AFFAIRS OFFICER AND ACTING ASSISTANT SECRETARY FOR POLICY AND PLANNING, DEPARTMENT OF VETERANS AFFAIRS ACCOMPANIED BY ANTHONY T. HAWKINS, EXECUTIVE DIRECTOR, CHIEF MINORITY AFFAIRS OFFICE; DR. ANGEL TORRES, HISPANIC PROGRAM MANAGER, AFFIRMATIVE EMPLOYMENT SERVICE, OFFICE OF EQUAL OPPORTUNITY; DAVID BRIGHAM, DIRECTOR, EASTERN AREA OFFICE, VETERANS BENEFITS ADMINISTRATION; DR. GALEN L. BARBOUR, ACTING DEPUTY UNDER SECRETARY FOR HEALTH; DR. GUSTAVO R. MARTINEZ, ACTING DIRECTOR, READJUSTMENT COUNSELING SERVICE; AND, JOSE CORONADO, DIRECTOR, SAN ANTONIO VA MEDICAL CENTER, SAN ANTONIO, TX

Mr. BURGE. Mr. Chairman, and members of the subcommittee, it is an honor to appear before you this morning to discuss health and benefit needs of our Hispanic veterans.

Mr. Chairman, I have submitted my testimony which describes what we are doing in the CMAO area. We really welcome this opportunity to participate in what we hope will be an annual proceeding, to work with you and to learn more about how we can better serve our Hispanic veterans.

Hispanic veterans comprise 900,000 individuals who have served in our Armed Forces, 40,000 of whom are female veterans. While they represent 3.4 percent of the veteran population, the number of individuals who have served their country, when we look at the various periods of service, is much more revealing. We find a much higher representation of Hispanic veterans in the Vietnam era and in the post-Vietnam era.

Because issues of concern of Hispanic veterans cross organizational lines within VA, I brought with me several officials who are available to answer questions the subcommittee may have in areas of particular importance to the subcommittee and to Hispanic veterans. These individuals include Tony Hawkins, Executive Director of the Minority Affairs Office; Dr. Angel Torres, our Hispanic Program Manager in the VA Office of Equal Opportunity; Mr. Dave Brigham, who as Director of the Eastern Region is representing our Veterans Benefits Administration; Dr. Galen Barbour, who is our Acting Deputy Under Secretary for Health; from San Antonio VA Medical Center, Mr. Jose Coronado, hospital director; and Dr. Gustavo Martinez, who is the Acting Director of our Readjustment Counseling Service.

I want to say very briefly, Mr. Chairman, that in the Chief Minority Affairs Office area our duties are pretty straightforward. These duties were provided and directed by Congress. First, to look at our current programs and to see if there are barriers which prevent minority and female veterans from fully participating in those programs. This morning we have heard about some of the problems in this area.

The second, and perhaps harder area, is to look at our programs and decide whether or not, as presently constituted, they are meeting the real needs of our minority and female veterans.

Our approach has been to work with our line managers in the Health and Benefits Administration and cemetery areas, and to enlist the personal help of the Secretary. There was a question raised during the hearing about how we better manage these problems that cut across lines, like the homelessness issue. I would like to say that there is a big change. In the past VA really never participated in problems that spilled outside of our Department but that has changed.

One question that was raised was our involvement in issues such as the homeless area. Secretary Brown did step forward and insisted that he be Co-Vice Chairman of the Interagency Council on the Homeless within the *White House* that is developing a coordinated plan to not only serve the needs of our veterans but all Americans who are faced with homelessness problems.

Within the Chief Minority Affairs area, much has been done over the last few months since the Secretary established for the first time a Minority Affairs Office and a Women Veterans Program Office. These offices did not exist in the past and there was not a means to really keep a continued focus on issues of great importance to our minority and female veterans.

As you know, Mr. Chairman, we are in the process of setting up a minority affairs network which will extend down to our facilities. We will have a means to not only see what is happening at the

local level but, in fact, to assess those efforts and to see if we need to change national policies.

As part of that effort, we are also going to build on many of the mechanisms already in place. We have a VA Hispanic Working Group within our RCS area that Mr. Martinez, one of the previous witnesses, is a member of. We would like to include this group in our network because they have great knowledge and information that would be useful to us in our CMAO process.

Mr. Chairman, because I know there is great interest in various areas that Hispanic veterans have raised with us, including our recent meeting with the new National Commander of the American GI Forum of the United States, Commander Alarid, I would like to give the subcommittee as much time as possible to discuss issues of concern to you with my colleagues and me.

Thank you, sir.

[The prepared statement of Mr. Burge appears at p. 130.]

Mr. EVANS. Thank you very much.

Your statement reports 925,000 Hispanic veterans. Does that number include Hispanic veterans living in Puerto Rico?

Mr. BURGE. That number, sir, was the Census number for veterans in the United States, that is the fifty States and DC. We have worked with the Census recently, and I do have a booklet specifically on Puerto Rico which has those veteran numbers, which I would be happy to share with the subcommittee.

Mr. EVANS. Mr. Hawkins, welcome back before the committee again.

Mr. HAWKINS. Thank you.

Mr. EVANS. I understand you recently visited Puerto Rico?

Mr. HAWKINS. Yes, sir.

Mr. EVANS. What were some of your observations and conclusions?

Mr. HAWKINS. As the Commissioner from Puerto Rico mentioned earlier, my observations were that the hospital has a problem with overcrowding. They have a problem with veterans getting timely services, especially in the outpatient area.

Some of the problems are due to the physical plant, and that will be resolved with the approval of the Ambulatory Care Center that is supposed to begin construction next year, I think.

We also noticed a problem with access to VA. On the island there is only the one hospital, but they have two outpatient clinics. One outpatient clinic is located in Ponce, which is located to the south of the hospital. The other one is located in Mayaguez, which is located to the west of the Medical Center.

The island does not have a public transportation system, therefore veterans, making arrangements to get to the hospital, must take almost 6 or 7 hours to get to the Medical Center. Upon arriving at the Medical Center, most of them arrive about the same time, very early in the morning, which adds to the crowding problem. But that is due to the way the transportation is set up.

After arriving at the Medical Center they have to wait. They also travel with their families. As one of the other witnesses mentioned, family is very important to Hispanic culture. So the family members add to that crowding phenomena at the Medical Center.

The Medical Center is attempting to address the issue, often-times not successfully. But I am hoping that with the building of the Ambulatory Care Center, that problem will be alleviated.

I don't know what you are going to do about the transportation problem, which is I think, a problem that the government of Puerto Rico is going to have to address.

Mr. EVANS. Noting the importance of the family, my understanding of the Clinton health care plan, which, of course, will not be enacted this year, is that it might have a major positive impact on veterans and their families, if not immediately, in the long term. Not only veterans, but their spouses and children would be offered the opportunity to use the VA system or to go to a private health care provider.

Is that problem going to continue to persist without the passage of some kind of increased funding for the VA for outpatient clinics and additional services in the VA as far as Puerto Rico is concerned?

Mr. HAWKINS. I think with Puerto Rico, as was mentioned earlier, the veteran would choose to use VA facilities. The other community hospitals are not up to the standards that VA's medical facilities are.

If we were to expand entitlement to family members, I think that might add to the problem, because the veterans would elect to bring their family members to VA.

Mr. EVANS. That was what the Clinton health care plan would have allowed, correct?

Mr. HAWKINS. Yes, right.

Mr. EVANS. Maybe this is one instance in which the VA might offer healthy competition to the other hospitals, private sector and the charitable organizations.

I just wanted to emphasize that given the fact that the family is so important to Hispanic veterans and the fact that some of the other providers aren't up to the par of the VA. I can see not investing in the VA as we intended with that legislation also aggravating the problem and not providing the money to build the facilities we need, if not in Puerto Rico throughout the rest of the country, for veterans, and particularly its impact on the Hispanic veterans.

Dave, approximately how many Hispanic veterans' organizations have representatives of the Chief Minority Affairs Office met with during the last 6 months? How were these organizations identified?

Mr. BURGE. Initially, Mr. Chairman, our meetings at the national level were focused primarily with the American GI Forum. The Congress helped us, Senator Akaka's office, to arrange a kick-off meeting with their representative. Since that time when the Chief Minority Affairs Office and the Women Veterans Program Office was set up, we worked through our veterans liaison officer to meet not only with that organization but the other organizations which have significant Hispanic representation in certain parts of the United States.

We also, during the interim period when we were trying to kick the CMAO function off, took advantage of trips that were already planned by our equal opportunity staff to also contact groups. That contact was primarily with groups in the Northeast which represent Puerto Rican veterans.

Mr. Chairman, we also have sent Tony Hawkins to Puerto Rico to take part in the hearings that Congressman Gutierrez was holding there and to meet with veterans.

And lastly, I would like to point out, sir, that we had a meeting last week with our Deputy Secretary and National Commander Alarid to describe how we can strengthen our relations on a more ongoing basis. They have designated a representative in Washington that they would like to represent them. We have begun an information exchange, and we are also very supportive of the efforts that they share with us to have the GI Forum play a more active role in Puerto Rico and other parts of the United States.

Mr. EVANS. If there is an Hispanic organization that is interested in getting involved in this, do they contact you directly?

Mr. BURGE. Yes, sir.

Mr. EVANS. What steps is the VA taking to make programs more culturally sensitive to Hispanic veterans, specifically the language barrier problem?

Mr. BURGE. I would like to open with a brief statement, sir, before I ask the other witnesses to participate. Language barriers is one of the first areas that the CMA Office has stepped into. We have a group that we put together from our three administrations to address that area. I would like Mr. Brigham from VBA to describe what is happening in his area, and Tony Hawkins to discuss things we are doing at the departmental level.

Mr. BRIGHAM. A couple of things I would raise from the veterans benefits standpoint, Mr. Chairman. The first is that there has been a steady growth in the number of frontline employees who are of Hispanic heritage and who are bilingual. We are now at 9 percent of our veterans benefits counselors who are Spanish-speaking and of Hispanic ethnic heritage.

In addition, we do have a publication in Spanish, a specific benefits publication we refer to as "Sus Beneficio," "Your Benefits," which has had wide use. It is in republication right now.

What we did with that was run it through focus groups in the Southwest, in Puerto Rico, and in New York City. The focus groups consisted of Hispanic veterans who helped us in restructuring that particular pamphlet, finding ways that both make it more culturally sensitive and, more specifically, more benefits useful. And hopefully that will be of significant benefit in the future.

One of the areas that has been raised in the past that we have explored but have not acted on is whether some or all of our benefits applications should be prepared in the Spanish language. We have considered that. To this point that change has not been made.

It seems to me that as we continue to address that, if we are going to specifically think about that seriously, we need to look in the survivor's benefits area where the majority of our language difficulties seem to arise.

Mr. HAWKINS. Some other areas that we have started to explore in the area of the problem of language, we put together a task force that did a survey of our facilities to find out how many had people capable of serving as translators for veterans who might appear at our facilities who spoke another language. Of a hundred and, fifty medical centers that responded, 25 specifically had programs and people who are available to assist as translators. Other facilities

that did not have a significantly large population of Hispanics, for instance, in their area had available to them people who could become—come down to the area to help them with communicating with that individual.

We also have our pharmacy service which is beginning to explore the labeling of medications in Spanish. Some of our public affairs documents have been produced in Spanish. Our "Federal Benefits for Veterans and Dependents" is one of those documents.

The earlier editions have the introductions done in Spanish, but the entire publication will be done in Spanish in the future.

Mr. EVANS. If I may interrupt you briefly. Of those 25 that have translating ability on more or less a permanent basis, are they in larger cities?

One of my concerns is I have a very significant sized population of Hispanic veterans in my district, who are served by the Iowa City, IA facility. I don't know if they have translation capabilities. It is a real problem where you have a smaller number of Hispanics who disproportionately are veterans but don't have those capabilities?

Is that what you found in your survey so far?

Mr. HAWKINS. That is what we found.

Mr. EVANS. Please excuse the interruption and please proceed.

Mr. HAWKINS. One of the things that we have been advised is sometimes a national solution is not always going to help a local situation. So what we are going to try to concentrate on are those facilities that have significant minority populations to increase their efforts to provide translation services and other enhancements to make our facilities and our programs more user friendly.

Mr. EVANS. Let me yield to the Congressman from Texas. I will probably have additional questions later.

Mr. TEJEDA. Thank you very much, Mr. Chairman.

You have heard the testimony of the panels that went before you, and you have heard some of the questions that we have asked.

One of the questions that I had asked was coordination among the Department of Veterans Affairs and the other agencies or departments, whether it is HUD or Labor or Education, Health and Human Services, and right on down the line. Is there that type of coordination? Is there a mechanism set up to coordinate this?

It was mentioned that during the Carter Presidency there was such a mechanism and that it was working. Is there one in place now? Or is there that coordination?

Mr. BURGE. As I pointed out, Congressman Tejeda, in the homelessness area, the Secretary did step forward to take a leadership role, because it is an area that is lacking coordination and we do have to have a Federal plan.

In terms of what some of the earlier witnesses raised related to our relationship with some of the key departments like Labor, I would like Dave Brigham to comment on that, sir.

Mr. TEJEDA. So, was your answer that you do lack the coordination and there is that—that mechanism is not in place?

Mr. BURGE. Well, in some areas it is strong and ongoing, like in our training area.

Mr. TEJEDA. But not for the total?

Mr. BURGE. In terms of areas like the homeless effort we need a national plan.

Mr. BRIGHAM. I think I would reiterate that. And I think the answer is to some degree satisfactory and to another degree, not.

In the area, for example, of services to transitioning service members, people coming out of service now, I think the level of co-operation is quite strong among Defense Department, Department of Labor and VA and the State Employment Service activities.

Clearly, the area of homelessness is an area in which we are all struggling. There is no question about that. But there are inter-agency efforts and Federal-state-local efforts that are collaborative in nature and really do speak to that.

There is a high degree of information referral between and among Federal and State agencies. But I believe your question drives to the point of some national coordinating process on behalf of veterans, and where we may have collaborative efforts between VA and OPM on preference and VA and Labor on certain employment activities, there is clearly the lack of a national umbrella that focuses that information referral system.

Mr. HAWKINS. However, may I add that in our benefits book, for instance, that is made available to veterans, in the rear of that pamphlet is information about other veterans programs that other Federal agencies may administer.

Mr. TEJEDA. Let me ask, and it was brought up that—you mentioned that there is some, in some areas coordination between Federal agencies and also between State. You heard me ask are the States doing enough? Should they do more? And is there that co-ordination there at all levels? For example, do you know what each of our 50 States is doing? Do you have a list of their veterans programss or their outreach for programs to veterans in terms of programs? And is that list available? Could someone take that list and say, you know, Texas is really the best State in terms of veterans programs, or Illinois, or California, or Kansas, you know, whoever it may be? Do you know what is going on out there in the States?

Mr. BURGE. I would ask Dr. Martinez of RCS which has the most ongoing relationship at that level to address your question, sir.

Dr. Gustavo R. MARTINEZ. First of all, I would like to say, Mr. Chairman, thank you for this historic hearing on Vietnam veterans and on veteran Hispanic affairs. I have been with the movement for the last 20 years, 12 years in a leadership role. So, I am fully aware that this is extremely historic, and an emotional moment for me in particular.

And I am very pleased, Congressman Tejeda, you know, to have you on board. Certainly it is symbolic of the type of leadership we need to get issues going for Hispanic veterans.

We have at the present time a national advisory committee on Vietnam and other war veterans which is comprised of a cross section of membership that are external to the VA that constantly give us feedback on a quarterly basis, meeting in different locations of the United States, about what is happening with veterans, especially war veterans. That serves as an excellent vehicle for us to generate up-to-date information on how we can better intervene to help war veterans.

As regards Readjustment Counseling Services and the Vet Centers, we have our National Working Group which is present here today, which also represents members from the different communities across the country, the VA, who constantly interact with the outside agencies and give us feedback on what is it that we need to correct or what is it that we need to address in order to better help our Nation's veterans.

And one of these groups in particular is the National Hispanic Working Group, which has membership from each region, each region, of course, being comprised of several States. And via that mechanism we are able to generate valuable information on staying up-to-date with many of our veterans in our communities.

Mr. BURGE. The other thing I would like to add, Congressman Tejeda, is one of the new initiatives being pushed by the Secretary is a renewed relationship with the State Veteran Service Offices. In the past, many have complained that they have not been part of the dialogue with the Department. We have done an excellent job of maintaining relationships with our veteran service organizations. We have set up mechanisms like participating with these groups in their conferences, so that we can better enlist their help and address your concern about the relationship with them.

Dr. Gustavo R. MARTINEZ. I guess one further example, Congressman, is that the Texas Veterans Affairs Commission and the Texas Veterans Land Board are very active components with our Texas Vet Centers, which there are 13 Vet Centers.

Mr. TEJEDA. Again, Dr. Barbour, if I were to ask you do you have a list, a comparison of what State programs are available, for example, you could tell me? Dr. Martinez answered that Texas has a veterans housing assistance program. They have a Texas veterans land program. California does not. Illinois does.

I mean is there a comprehensive list of State-by-State veterans programs? Texas—or State programs available to veterans?

Mr. BURGE. Not that I am aware of. We do have what would be pieces of such a list. But you raise a good point in terms of having to pull that together.

Mr. TEJEDA. I think it would be helpful if the Department of Veterans Affairs knew what the different States are doing.

Could you tell me how many States or which States have State veterans homes? And which do not?

Mr. BRIGHAM. Let me interject, if it is all right. We do maintain that type of information in the regional office system. In many cases our VA regional offices around the country are, in fact, the certifying authority for some of those State and local benefits, providing verification of service or service-connected disability status or something of that sort.

So, we do have information regarding State and local benefits for veterans covering education, bonuses, hunting and fishing licenses, license plate benefits, and so forth and so on. And that is available in the system.

Mr. TEJEDA. I know at one time there was, I believe, a VA program, if I am not mistaken, that would provide 75 percent of the funding if a State would put in the 25 percent for a veterans home. Is that still basically correct? Is that program in place?

Dr. Gustavo R. MARTINEZ. Yes. That program is still operational. They will provide up to 65 percent of the construction, and then they let the States take it over and then further subsidize on a per diem basis.

However, before the VA can even begin to initiate such a move the States first have to initiate their commitment for the continued funding, especially ongoing operational costs, after the VA puts up their 65 percent.

Mr. TEJEDA. Well, I guess somewhere in your files, if you don't have it readily available, you would know which States have State veterans homes and which do not?

Mr. BURGE. Right. The point I was trying to make, sir, is we have lists for the various types of activities that we are involved in. But I believe your question related to pulling them all together in one place.

Now, I would like to point out that in our medical area as part of health care reform there was a recognition that VA would have to be able to have information to know what was going on at the State level. Dr. Barbour can talk about the Project Management Office and their efforts to try to develop that kind of information, because we know the States aren't waiting. It would include a lot of information that you are referring to.

Dr. BARBOUR. Thank you, David.

Yes, Congressman, we do have an office, an active office right now trying to put that kind of information together predominantly for the medical benefits, not for the non-medical benefits. The Benefits Office, I understand, has that.

I also would like to point out that in most local health care facilities, whether it is an outpatient clinic or a VA Medical Center, the local social workers are aware of State programs and other local programs to which they can refer veterans who qualify for that. We do not, to my knowledge, have that yet rolled up at the national level, and that is part of what our Health Care Reform Office will be accomplishing.

Mr. TEJEDA. Do you think that would be helpful, though? I certainly do, if you would have that information available here.

Dr. BARBOUR. It certainly would be. That is why we are trying to pull it together. Yes, sir.

Mr. TEJEDA. Tell me what type—do you have an ongoing program or coordination in working with the VSOs, whether it is the Veterans of Foreign Wars, The American Legion, the GI Forum, and all the other VSOs? Do you all have any—do you all get to come together from time to time or do you all have some mechanism or organization out there that gets together to exchange information?

Mr. BURGE. Yes, sir. Perhaps one of the biggest changes that those of us who have been with the Department for many years have seen is a change in the way that our top level interacts with veteran service organizations. Specifically what I am referring to is the veterans service liaison office's new role, which is not surprising given our Secretary's background. That is working with our veterans' service organizations during the policy deliberations rather than what has traditionally been in the past announcing the end result. And I think that is very strong and ongoing.

Mr. HAWKINS. I also know that on a routine basis the service organization heads, here in Washington, DC, meet with the Secretary's Special Assistant for Veterans Liaison, and also I know that the Under Secretary for Health has a routine meeting, I believe on a monthly basis, with the veterans' service organizations.

The Veterans Benefits Administration also meets on a regular basis, and at the local level our Medical Center Directors and our Regional Office Directors meet, if not monthly, at least quarterly, with veterans' service organizations. When there are special issues that they need to be made aware of, I think they notify them immediately.

Dr. Gustavo R. MARTINEZ. If I can just add that we also go farther than that, and we have been doing joint training at the community level with the American GI Forum.

Mr. TEJEDA. I was speaking at a general level with all the VSOs. Now, specifically with Hispanic veterans' organizations or with some of the people who are out in the trenches as the previous panel before you, do you all have that particular outreach or connection between you all? And have you all identified some problems that are maybe specific to Hispanics?

Mr. BURGE. Yes, sir, we have. As I mentioned earlier, we had the opportunity to meet with the new National Commander of the GI Forum and the dialogue is continuing. He has designated Dr. Soto, who is here in Washington, to be their representative. We have already started an information exchange. Many of the areas that they shared with the subcommittee this morning they have already shared with us.

But the hard part comes in making improvements in those areas that they have identified, and that we see as our task.

Mr. TEJEDA. When did you all meet with the GI Forum?

Mr. BURGE. The most recent meeting, sir, was last Friday with our Deputy Secretary and myself.

Mr. TEJEDA. Mr. Hawkins, you were going to say something?

Mr. HAWKINS. I think at the local level, now that we have had approval for the CMAO structure to be in place at the local level, we would see the minority affairs liaisons or coordinators working with the community-based representatives, with the GI Forum local chapters, to network to identify what the concerns are and to work together to resolve those concerns.

Personally, as I have traveled around the country, as I have attended conferences and meetings here in Washington, I make a point of letting folk know who I am, passing around my business card, making my phone number available to these people, and when folks call me, they are surprised that I answer my own phone. But I tell them that you called to talk to me, so that is who you have reached.

Mr. TEJEDA. Mr. Coronado, welcome, Jose. Good to see you.

I would just like to say, Mr. Chairman, and to others, that Jose Coronado is an outstanding administrator there at the Audie Murphy Hospital, and in fact reaches out, meets with the programs, and is constantly there.

If there is anything lacking it is not because of his fault, but because of lack of resources. And I think we here in the Congress have to accept that major responsibility.

But, you know, Jose, let me ask, if I may, you know there are certain illnesses or diseases that may affect Hispanics more so than others. For example, diabetes falls disproportionately among Hispanics.

How has the VA, or perhaps your facility in particular, addressed these unique problems confronting Hispanics?

Mr. CORONADO. Well, first of all, the population in Texas for Hispanics runs about 270,000. Half of that population is in the San Antonio primary service area.

We, of course, have no problem in communicating with our veterans because half of the staff is Hispanic. All of our patient representatives speak Spanish. The nursing staff is very fluent in Spanish for patient education purposes. And we consider ourselves very fortunate in that regard.

The Audie Murphy Hospital is also one of the largest organizations because not only do we have a hospital, we have a 120-bed nursing home, a 30-bed spinal cord injury unit, 3 satellite clinics and 2 community-based clinics, 4 Vet Centers and 2 cemeteries that we are supporting.

But having said all that, one of the issues that concerns us, of course, is the illnesses that Hispanic veterans present, diabetes is, of course, the most prevalent, but we move on to others, and we have many research studies that are going on.

We have one program that has the acronym of MERCE, which means "deserves." And the program addresses itself to the needs of the Mexican-American elderly and their families, as regards not only diabetes but in dealing with nursing home care, which is a problem for Hispanics in that we do not like to put our relatives in nursing homes. And we have to address how we approach the issue of age among Hispanics.

The issue of dealing with depression, depressive disorders, PTSD is also high in the research activities of the Project MERCE.

The Texas Diabetes Institute based in San Antonio deals with all aspects of diabetes. We have a world-renowned diabetes specialist, Dr. Ralph A. DeFonzo, who is employed by the VA Medical Center in San Antonio and has conducted many studies, many of them based at the VA among these is the identification of diabetes genes.

We develop prostheses required after amputations due to the problems with diabetes.

We have another program called Salsa, another Hispanic acronym. Salsa stands for San Antonio Latino Study of Aging, and that whole effort is aimed at the aging Hispanic American and their problems and their needs, and those of the family.

The Hispanic Healthy Aging Center is another component of our program, and we continue to outreach to the veterans, the Hispanic veterans, to see what other needs they might present.

Mr. TEJEDA. Thank you very much.

You know, I represent a district in south Texas going from Comal County all the way to the border with Mexico, and we have one hospital there and that is the Audie Murphy Hospital. Many of the veterans—and you heard my distinguished colleague Solomon Ortiz mention that for years we have been trying to get a hospital or a large facility in south Texas. Many of the veterans have to travel 250 miles or more.

And, while I realize that there is some outreach clinics there or outpatient clinics, I believe those may be filled to maximum capacity now. Has that been studied? Has that been recently looked at and analyzed, and what is being done?

I mean one just needs to look at the map of Texas and you see the Audie Murphy in San Antonio and then in the rest of south Texas there is no major facility other than some outpatient clinics. And perhaps you can enlighten me in terms of, I believe, a couple of them may be up to maximum capacity now.

Dr. BARBOUR. Congressman, I am afraid I can't answer that question. I am not aware of any specific population studies. I do know that our construction budget and construction plans over the last couple of years have been looking at that particular issue, and I am just not cognizant of that specific issue, but I would be happy to correspond with you later and give you an answer to that.

Mr. EVANS. Please submit that to the committee for inclusion in the record.

Dr. BARBOUR. I would be happy to do so.

Mr. TEJEDA. If you would, please.

(Subsequently, the Department of Veterans Affairs provided the following information:)

Over the past several years, the VA has conducted a series of feasibility studies to determine the need for an inpatient facility located in the Rio Grande Valley. In August 1993, an update to the 1988 feasibility study to determine the need for a VA Medical Center in the Rio Grande Valley was completed using data from the 1990 Census and workload data from the most recent, complete fiscal year. The "bottom line" of this updated study substantiated earlier results which indicated it would not be feasible to build a VA Medical Center in the Rio Grande Valley without severely affecting existing facilities. For example, workload drawn to a newly constructed VA inpatient facility in the Valley would require nearly a 40 percent reduction in beds at VAMC San Antonio.

The updated feasibility study also confirmed the continuing demand in the area for outpatient care which appears to have decreased the need and the demand for inpatient care. As a result, the discharge rate of veterans residing in the Rio Grande Valley at existing VA medical centers is slightly lower than the national discharge rate. Conversely, the outpatient visit rate of veterans residing in the Rio Grande Valley at existing VA facilities is significantly higher than the national outpatient visit rate largely due to efforts of the Southern Region to upgrade existing clinics and to open community based clinics.

The Corpus Christi SOC (Satellite Outpatient Clinic) was opened in 1972, beginning as a small operation. After relocating in 1987 to a more spacious site with additional staff (8 FTEE) provided by the Region, the workload has continued to increase to nearly 30,000 visits by the end of FY 1994. Also established in 1972, the McAllen SOC began as a small clinic. With additional staffing (9 FTEE) provided by the Region in FY 1987 and FY 1988, this clinic was relocated to a 27,000 square foot facility in August of 1991. As a result of these efforts, the FY 1994 workload for McAllen exceeded 29,000 visits. The Southern Region was also instrumental in planning and activating the Laredo CBC (Community Based Clinic) in May 1990 and the Victoria CBC in November 1989. A summary of the capacity at each clinic is provided below:

Corpus Christi Satellite Outpatient Clinic:

According to data provided by the San Antonio VAMC, the Corpus Christi clinic is at capacity with their FY 1994 workload of 29,454 visits. The most recent update of a Valley hospital feasibility study showed that veterans residing the Corpus Christi area are receiving outpatient care at a level exceeding the national average visit rate. Outpatient workload projected for the year 2005 is 24,702.

McAllen Satellite Outpatient Clinic:

According to data provided by the San Antonio VAMC, the McAllen clinic is at capacity with their FY 1994 workload of 29,129 visits. The most recent update of a Valley hospital feasibility study showed that veterans residing the McAllen area

are receiving outpatient care at a level exceeding the national average visit rate. Outpatient workload projected for the year 2005 is 30,000 visits.

Laredo Community Based Clinic:

According to data provided by the San Antonio VAMC, the Laredo clinic is below capacity with a workload of 11,879 visits in FY 1994. San Antonio estimates the clinic could accommodate up to 12,500 visits which would be nearing capacity. The most recent update of a Valley hospital feasibility study showed that veterans residing in the Laredo area are receiving outpatient care at a level exceeding the national average visit rate. Outpatient workload projected for the year 2005 is 12,676 visits.

Victoria Community Based Clinic:

According to data provided by the San Antonio VAMC, the Victoria clinic is below capacity with a workload of 9,883 visits in FY 1994. San Antonio estimates the clinic could accommodate up to 10,000 visits which would be nearing capacity. The most recent update of a Valley hospital feasibility study showed that veterans residing in the Victoria area are receiving outpatient care at a level exceeding the national average visit rate. Outpatient workload projected for the year 2005 is 10,236 visits.

In summary, past feasibility studies to determine the need for an inpatient facility do not support building a VA medical center in the Rio Grande Valley. The studies do support, however, past actions taken to expand the clinics in Corpus Christi and McAllen, Texas and establish new outpatient facilities in Laredo and Victoria, Texas. Population projections based on the 1990 census project a continuing decline in the veteran population residing in the Rio Grande Valley. This trend is observed in the year 2005 outpatient projections for these facilities, which in every case, are very close to what has been determined to be the maximum capacity for the south Texas clinics.

THE NEED FOR A VA MEDICAL CENTER
IN RIO GRANDE VALLEY

FEASIBILITY STUDY UPDATE

August 20, 1993

BACKGROUND

For the past several years, the Southern Region has received an increasing amount of correspondence from the Rio Valley urging the Veterans Administration to establish an inpatient facility. In order to fairly and adequately respond to these concerns, the Southern Region decided to update a feasibility study completed in FY 88 by former Medical District #20 staff. After obtaining a copy of this study, the Region began the task of gathering the required data and information. The criteria in the study were applied to four areas in the Valley where the most correspondence was received. These areas include:

1. Cameron County (Brownsville/Harlingen)
2. Nueces County (Corpus Christi)
3. Webb County (Laredo)
4. Hidalgo County (McAllen)

CRITERIA

The following criteria were selected as the most important for evaluating and ranking proposed hospital sites. Each of the criteria was evaluated as the relative importance of each. This relative importance is reflected in the weights assigned each criterion (e.g., Population Served is considered a more important criterion than Access as denoted by their weights, 8.3 and 5.8, respectively).

Population Served: This criterion was considered the most important because the more new (previously unserved or underserved) veterans a proposed hospital could serve, the more desirable it was. This criterion was assigned the highest weight (8.3) relative to the other criteria.

Access: This criterion measures a combination of distance and population from an existing VA Medical Center (VAMC) compared to the proposed VAMC. This was considered important because the farther away a veteran is from a VAMC, the less likely that veteran is to use the VAMC. The Access Index takes into account the straight line distance from existing and proposed VAMC theoretical primary service areas (PSAs) to the center of the veteran population within those counties (the centroid) that make up the theoretical PSAs of the proposed sites under study. Accessibility to a VAMC was considered second in importance (weight 5.8) only to population served.

Impact on Other Facilities: This criterion assumes that a proposed hospital that takes away a significant amount of workload from an existing VAMC is less desirable than one that takes little, if any, workload away. The rationale is that if there is a considerable impact on the workload of an existing VAMC, then those veterans are already receiving care from existing VAMCs. This criterion was considered only slightly more important (weight 4.6) than the Usage criterion. (weight 4.5).

Usage: This criterion measures the disparities in veterans' participation in the VA health care system. The theoretical PSA's projected inpatient discharge and outpatient visit rates (year 2005) were compared to the national average projected discharge and outpatient visit rates to determine how far below or above the national average the area under consideration is projected to be. The national average discharge rate and outpatient visit rate are considered to be the points of equality for VA inpatient and outpatient care, respectively.

In general, the basic steps taken to determine the level of potential of geographic area for a new VAMC were (1) determination of the proposed VAMC's theoretical PSA; (2) determination of the year 2005 veteran population for that PSA; (3) determination of the "access index" for the theoretical PSA; (4) calculation of year 2005 projected inpatient discharge rates for each theoretical PSA; (5) calculation of year 2005 projected outpatient visits and outpatient visit rates for theoretical PSAs; (6) calculation of the amount of negative impact a proposed VAMC could potentially have on existing VAMCs.

APPLICATION OF THE METHODOLOGY:

In reviewing the Tables below, it is important to refer to the formula for each criterion as found in Attachment B.

Table 1 shows the results of applying the first criterion, Population Served. Projected year 2005 veteran population statistics are used. The proposed facility theoretical PSAs are listed in priority order by the home county of the potential VAMC PSA. In order to standardize the scores, the theoretical PSA with the largest veteran population (Nueces, Texas) was given ten points, and all others were given a proportional number of points depending on their population as compared to the largest. The points each theoretical PSA received were then multiplied by the criterion's weight to arrive at a final score.

TABLE 1
NEW VETERAN POPULATION SERVED

THEORETICAL PSA COUNTY	2005 PSA VET. POP.	POINTS	WEIGHT	SCORE
Nueces	92,957	10.0	8.3	83.0
Webb	78,026	8.5	8.3	70.6
Hidalgo	73,746	7.9	8.3	65.6
Cameron	66,860	7.2	8.3	59.8

Table 2 shows the results of applying the second criterion, Access. The potential sites' theoretical PSAs are listed in priority order by county of location. In order to standardize the scores, the theoretical PSA providing the greatest improvement in access (Nueces, Texas) was given ten points; and all others were a proportional number of points depending on the amount of improved access they provided as compared to the largest. The points each theoretical PSA received were then multiplied by the criterion's weight to arrive at a final score.

TABLE 2
IMPROVED VETERAN ACCESS

<u>THEORETICAL PSA COUNTY</u>	<u>DISTANCE TO NEAREST VA</u>	<u>INDEX</u>	<u>POINTS</u>	<u>WEIGHT</u>	<u>SCORE</u>
Nueces	134	9,195	10.0	5.8	58.0
Hidalgo	222	8,537	9.2	5.8	53.4
Cameron	240	7,149	7.8	5.8	45.2
Webb	145	4,928	5.4	5.8	31.3

Table 3 shows the results of applying the inpatient portion of the Usage criterion. The potential sites' theoretical PSAs are listed in priority order by county of location. In order to standardize the scores, the theoretical PSA that shows the greatest disparity in inpatient care to veterans as measured by having the lowest discharge rate above the national average discharge rate (Nueces, Texas) was given ten points, and all others were given a proportional number of points depending on their discharge rate as compared to the lowest. The points each theoretical PSA received were then multiplied by the criterion's weight to arrive at a final score.

TABLE 3
NEW INPATIENTS SERVED

<u>THEORETICAL PSA COUNTY</u>	<u>1992 VET. POP.</u>	<u>1992 DCHG</u>	<u>DCHG RATE</u>	<u>NTL. RATE</u>	<u>VLU</u>	<u>NRM. PTS.</u>	<u>WEIGHT/ SCORE</u>
Cameron	78,654	2,226	28.30	35.84	2.10	10.0	3/30.0
Nueces	109,931	3,165	28.80	35.84	1.96	9.3	3/27.9
Hidalgo	86,078	2,484	28.88	35.84	1.94	9.2	3/27.6
Webb	90,490	2,820	31.16	35.84	1.31	6.2	3/18.6

Table 4 shows the results of applying the outpatient portion of the Usage criterion, percent below the national average outpatient visit rate. The potential sites' theoretical PSAs are listed in priority order by county of location. In order to standardize the scores, the theoretical PSA that shows the greatest disparity in outpatient care to veterans as measured by having the lowest percent below the national outpatient visit rate (Nueces, Texas) was given ten points; and all others were given a proportional number of points depending on their outpatient visit rate as compared to the lowest. The points each theoretical PSA received were then multiplied by the criterion's weight to arrive at a final score.

TABLE 4

NEW OUTPATIENTS SERVED

THEORETICAL PSA COUNTY	1992 VET. POP.	1992 VISITS	VST RATE	NTL RATE	VLU	NRM. PTS.	WEIGHT/ SCORE
Cameron	78,654	72,769	925.18	844.68	-0.95	10.0	1.5/15.0
Nueces	109,931	104,362	949.30	844.68	-1.24	7.7	1.5/11.6
Webb	90,490	90,687	1,002.18	844.68	-1.86	5.1	1.5/7.7
Hidalgo	86,078	88,050	1,022.91	844.68	-2.11	4.5	1.5/6.8

Table 5 shows the results of applying the fourth criterion, Impact on Other Facilities. The potential sites' theoretical PSAs are listed in priority order by county of location. Projected year 2005 discharges taken away from an existing VAMC by the proposed facility as a percent of the total year 2005 discharges from the existing VAMC provide and indicator of the impact on existing VAMCs. In order to standardize the scores, the theoretical PSA having the least impact on the inpatient workload of existing facilities with the highest figure under the "workload lost" column (Nueces, Texas) was given ten points, and all others were given a proportional number of points depending on their inpatient impact as compared to the lowest. The points each theoretical PSA received were then multiplied by the criterion's weight to arrive at a final score.

TABLE 5
IMPACT ON OTHER FACILITIES

THEORETICAL PSA COUNTY	YEAR 2005 WORKLOAD LOST	POINTS	WEIGHT	SCORE
Nueces	1.55	10.0	4.6	46.0
Cameron	1.11	7.2	4.6	33.1
Webb	1.12	7.2	4.6	33.1
Hildago	1.07	6.9	4.6	31.7

Note: The higher the score, the less impact a new facility would have on an existing facility.

Table 6 summarize the scores each potential site received under each criterion, totals the scores received, and ranks the potential sites against each other. The potential sites are listed in descending in order based on total score.

TABLE 6
SUMMARY OF SCORES AND FINAL RANK

THEORETICAL PSA COUNTY	VET. POP.	ACCESS	IP	OP	IMPACT	TOTAL
Nueces	83.0	58.0	27.9	11.6	46.0	226.5
Hidalgo	70.6	53.4	27.6	6.8	31.7	190.1
Cameron	65.6	45.2	30.0	15.0	33.1	188.9
Webb	59.8	31.3	18.6	7.7	33.1	150.5

ANALYSIS:

An examination of Table #1 shows that the Nueces theoretical PSA has the largest projected veteran population for the year 2005. The Cameron theoretical PSA has the smallest projected year 2005 veteran population (66,860) which is 72% of the Nueces theoretical PSA's projected veteran population.

Table #2 shows the effect, distance and population - Accessibility - have on the theoretical PSAs. It may be noted from the table that Cameron is the furthest from an existing VAMC. Generally speaking, establishing a VAMC in Cameron (Brownsville/Harlingen) would greatly increase the accessibility of VA services to veterans in the area. In the formula to compute the access index, however, Nueces is ranked first, while Cameron slips to third in terms of the access index.

Table #3 shows the level of disparity in inpatient care for each area studied compared to the national average. The disparity is measured by comparing the projected year 2005 discharge rate for veterans living in the designated theoretical PSA to the projected year 2005 national average discharge rate. The greater the difference, the greater the potential use in the theoretical PSA of inpatient services. In this table, veterans in the Cameron theoretical PSA are ranked the highest in the criterion.

Table #4 measures the disparity in outpatient care the same way Table #3 measured the disparity in inpatient care. Table #4 shows that veterans in the Cameron theoretical PSA rank highest in this criterion.

Table #5 measures the amount of inpatient workload a theoretical PSA could potentially take away from existing VAMCs inpatient workloads.. This Table indicates that a new VAMC in the Neuces theoretical PSA would have the least impact on existing facilities' inpatient workloads.

Table #6 summarizes the scores each theoretical PSA received against each of the criteria. Nueces ranks highest since it scored first in three of the five criteria (new veteran population served, access and least impact on existing facilities).

A preliminary analysis of bed projection for each of the potential VAMC locations was made using the veteran population for each of the PSAs and system-wide ratio of beds to veteran population. This analysis was developed for total hospital beds only. The following displays the beds projections for each of the potential VAMC locations:

TABLE 7
PROJECTED YEAR 2005 HOSPITAL BED NEEDS

THEORETICAL PSA	YEAR 2005 PSA VETERAN POPULATION	YEAR 2000 PROJECTED HOSPITAL BEDS
Cameron	66,860	194
Hidalgo	73,746	218
Nueces	92,957	276

Webb	78,026	232
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CONCLUSIONS:

Based upon information gathered and the analysis conducted, it appears that of all the areas studied, the Nueces County, Texas (Corpus Christi) theoretical PSA is more appropriate for the potential additional health care access than any of the other locations.

Although impact on existing facilities is addressed in the fourth criterion -- Impact on Other Facilities -- an additional means of viewing impact is to consider the number of beds that would be shifted from existing VAMCs to potential VAMCs. Because of the relatively close proximity of Corpus Christi to VAMC San Antonio (closer than any of the other potential locations to an existing facility), the impact of establishing a VAMC in Corpus Christi (Nueces) on VAMC San Antonio has been developed. Based on the size of the veteran population shifted away from VAMC San Antonio to Corpus Christi (Nueces), a proportionate number of beds would also be shifted to Corpus Christi. Of the total of 276 beds needed for Corpus Christi (Nueces), 270 beds would be shifted away from VAMC San Antonio, reducing the size of this facility by approximately 37%, therefore making it impractical to provide additional inpatient care in Corpus Christi (Nueces).

While veterans in the Corpus Christi area as well as the other Valley sites considered, have slightly reduced access to VA inpatient facilities than the national average, the overall outpatient visit rates in the Valley are now substantially higher than the national rates. This is not surprising since the Southern Region was instrumental in pursuing expansion of existing outpatient facilities in McAllen and Corpus Christi while establishing community-based clinics in Victoria and Laredo, Texas.

RANKING CRITERIA AND SCORING PROCEDURE FOR PROPOSED HOSPITAL SITES

In each case, criterion weight is multiplied by criterion score to obtain the points for each criterion. Points are summed for all criteria to obtain the total points used in ranking proposed hospital sites. The higher a site's score, the higher it is ranked.

<u>CRITERION</u>	<u>CRITERION WEIGHT</u>	<u>CRITERION SCORE CALCULATED AS FOLLOWS</u>
1. POPULATION SERVED		
Total 2005 vet pop in theoretical PSA.	8.3	Proposed site with highest PSA value receives a score of 10; others receive a score of Their value X 10 <u>Highest value</u>
2. ACCESS		
PSA Access Index Value (For each county in theoretical PSA: Distance to nearest VAMC minus distance to proposed site X vet population of county divided by 1000 = county value. Summed across all counties in PSA).	5.8	Proposed site with highest value receives a score of 10; others receive a score of Their value X 10 <u>Highest value</u>
3. USAGE		
a. % below national discharge rate.	3.0	<u>National Avg -PSA Discharge Rate X 10</u> National Average Discharge Rate
b. % below national average outpatient visit rate.	1.5	<u>Nat. Avg. OP-PSA OP Visit Rate X 10</u> National Average OP Rate
4. IMPACT ON OTHER FACILITIES		
Greatest % of 2005 inpatient workload lost by any one VA facility to the theoretical PSA, as determined by standard projection methodologies.	4.6	1 - % of 2005 inpatient workload lost X 10

Mr. TEJEDA. And in south Texas the vast majority of veterans there are Hispanics, and that is why I raise that issue. So, I would certainly like to see that, and certainly the most recent, if any, study or analysis done in that area.

I know the issue has been raised before but I personally have not seen any studies. So, I would like any and all studies that you have done in the past, but particularly the most recent.

Mr. Chairman, thank you very much.

Mr. EVANS. You are welcome.

I now recognize Minority Counsel.

Mr. SMITH. Thank you, Mr. Chairman.

Mr. Burge, a number of witnesses this morning have stated their concerns about the needs of homeless veterans, particularly, of course, Hispanic veterans. You mentioned VA's homeless program and Secretary Brown's efforts in that area, in your oral testimony.

Would you please elaborate on VA's homeless programs, their funding and their history, to supplement your written statement submitted for the record?

Mr. BURGE. Yes. In the homeless area we have had an increase, thanks to the help of Members of Congress, for that program. During the past year, funding was increased from \$50 million to \$70 million. In addition, for the first time, we were given special authorization to make grants to non-VA providers for homeless care. This week the Department is really stepping off to a new area and that is managing grant programs for homeless veterans. The announcements of grant recipients will be this week.

We have a homeless czar—one individual, who is accountable for the whole program, and the Secretary himself has participated in many of the stand-downs across the country.

We have also recently formed a partnership with the AmeriCorps program and obtained a half million dollars this year for specific projects that will assist homeless veterans.

Mr. SMITH. Mr. Chairman, thank you.

Mr. TEJEDA [presiding]. Mr. Burge, you, I guess within your records you know how many African American veterans are out there, how many Hispanic veterans are out there, and who is utilizing the services of the Department of Veterans Affairs.

In your opinion, based upon the number of Hispanic veterans, are they utilizing it? Is it being underutilized by Hispanic veterans, the services of the Department of Veterans Affairs? Or what is your opinion on that?

Mr. BURGE. Congressman Tejeda, part of our office's responsibility is maintaining national statistics for veterans. That includes periodic surveys of veterans, because we recognize that a lot of veterans don't come to VA. There is a study, sir, that is going to be concluded this month, which ran over the last 2 years, and one of the specific questions that we asked the respondents across the country was their knowledge of the various programs, which we would be happy to provide to you.

To answer your question, we also looked at participation rates. As the witnesses before us have pointed out, when we look at the results and we compare Hispanic veterans to their counterpart nonveterans the results look very good. When we do comparisons, however, with the larger number of white veterans we see the His-

panics falling in many instances at a lower level midpoint between white and African American veterans. Our objective will be to close those gaps.

We do have information for specific areas that we would be happy to share with you.

Mr. TEJEDA. Okay. So, you can't say at this point that Hispanic veterans are underutilizing VA services?

Mr. BURGE. No. For example, this morning there was a discussion on education, and in that area the Hispanic veteran participation rate is high. It is equal to that of the white veterans. When we look at other measures, however, like how many Hispanic veterans hold college degrees, we see a difference.

So, participation may not be the only issue we need to look at. We need to also look at what the results of that participation were.

Mr. TEJEDA. Thank you.

Mr. Coronado, what are the results of the Chicago pilot which targeted women, minorities and the handicapped VA employees for recruitment, training and placement in the VA's executive development program?

Mr. CORONADO. The Chicago pilot was initiated about 5 years ago. It was a project that had its beginning with the then Administrator of Veterans Affairs, Thomas Turnage, who was questioning why we did not have more women, minorities and people with disabilities in the higher executive ranks of the VA.

The committee started a review of the issues in trying to see the source of individuals who would enter the top management positions, which in our system is the Associate Director positions. We looked to see who would be the applicants; generally, these are the service chiefs of the different services (Departments) within the hospital, and found that we didn't have any women, minorities or people with disabilities in those positions. Then we surveyed the assistant chief positions and found that we didn't have any women, minorities or handicapped individuals in those positions either.

The committee then took on the job of trying to find ways of fast-tracking individuals from these groups through the system by setting up a special program; we picked Chicago because Chicago has difficulty recruiting people to come into the city because it is a high cost-of-living area. We felt that there would be a pay-off if we tried the project in Chicago and identified these individuals.

The project was set up to select 15 candidates. These were VA employees who would generally fit the categories of women, minorities and people with disabilities. The program was designed to take 2 years. The first year was a year of enhancement in which we essentially took the individuals and exposed them to some basic management theory, training, conducting meetings, how to dress—the whole issue of presenting themselves and being able to manage groups.

The second year was the Medical Administration Service training program that we have had in place for several years that trains people to become either chiefs of sections within Medical Administration or assistant chiefs in the Medical Administration service.

We put all 15 people through the 2-year program. I think we lost one in the process. These individuals have finished the training. All have been placed except one individual whom I spoke to last week.

The program has proven to be very successful. It also highlighted the fact that the VA as a Department was concerned about this issue and tried to resolve the issue.

I have personally noted that in the past 4 years I have had associate director trainees; four of them have been women.

So, the aim in the Department is to look for these individuals, encourage them, open the door, and provide training, if necessary, to prepare them to compete for those positions.

Mr. TEJEDA. Mr. Chairman, I have just one further, if I may, before the panel leaves.

You know recently it was announced, and I believe it is in the process of merging, consolidation of some services throughout the VA. I believe 8 out of the 33 that were targeted are in Texas. I believe some of the Waco functions and San Antonio functions may be brought together.

I have got a great concern. As I mentioned, one of the complaints most often heard, particularly from some of the counties in south Texas in my district is the lack of access. I have got a concern that this consolidation, this merger may impact upon services or upon services available or upon the quality of services.

Are there any assurances that some of the cutbacks in personnel, some of the bringing together of services or of functions will not impact, number one, on the quality and on the access to those services that are available now?

Mr. CORONADO. The project that you mentioned, consolidation of VA Medical Centers that fit a particular criteria, was initiated to accomplish the downsizing which we in VA are taking part in. The Administration and the Congress have indicated that the VA should reduce its staffing by some 500,000 within the next 4 to 5 years.

We have studied various ways that we might reduce staffing without affecting patient care. This has been the condition that the Secretary has put on downsizing. We can in no way diminish the amount of care that we provide patients.

In studying the options that we had, consolidation which calls for two or three VA Medical Centers to come together and eliminate all of the administrative support services, the personnel, the supply service, the fiscal service, and have all of that managed by one facility for both organizations, or three organizations as in the case of Waco, Temple and Marlin.

The feeling is that this is streamlining the organization and that we will not affect the delivery of care to patients.

The issue of whether this will diminish services to the patient is dependent on the way the plan developed. Right now we are merely in the planning stages there. The order to consolidate has not been issued.

In the preliminary stages the indication is that probably this will work well. That we might even be able to expand services in that we may have duplicative medical care services in 2 VA Medical Centers. Even though we are very close to one another, San Antonio and Kerrville, we retain our independence. We have always been proud within the VA of the axiom that "When you visit one VA hospital you have visited one VA hospital."

Health care reform is ongoing and we have seen that the private sector is reforming very quickly. VA has got to become more homogeneous. We have got to be able to pull together and conserve in as many areas as possible, and the area of administrative support is the area that we need to look to streamline.

At this point we are evaluating the process. The plans have been submitted to our headquarters here in Washington, and we have not yet been notified as to how we will proceed.

Mr. TEJEDA. Thank you, Mr. Chairman.

Mr. EVANS. I have some additional questions I am going to submit for the record. I appreciate you hosting the lunch. We are already late for it and we still have another panel.

There are some optimistic steps being taken here, and we encourage you to continue down that path. We will be looking forward to working with you on these issues.

(See p. 157.)

Mr. BURGE. Thank you, Mr. Chairman.

Mr. EVANS. Thank you.

The members of our final panel are Preston M. Taylor, Jr., the Assistant Secretary of Veterans Employment and Training Service, U.S. Department of Labor, and Leon Bechet, Assistant Administrator for Veterans Affairs, Small Business Administration.

Preston, we will start with you once you are seated.

STATEMENT OF PRESTON M. TAYLOR, JR., ASSISTANT SECRETARY FOR VETERANS' EMPLOYMENT AND TRAINING SERVICE, U.S. DEPARTMENT OF LABOR AND LEON BECHET, ASSISTANT ADMINISTRATOR FOR VETERANS AFFAIRS, SMALL BUSINESS ADMINISTRATION

STATEMENT OF PRESTON M. TAYLOR, JR.

Mr. TAYLOR. Good afternoon, Mr. Chairman, and members of the subcommittee. I am pleased to appear before you today and have this opportunity to discuss issues regarding the employment and training of Hispanic veterans.

I would request that my full statement be made part of the record of these most important proceedings.

Mr. EVANS. Without objection, so ordered.

Mr. TAYLOR. Thank you.

Throughout American military history, Hispanic Americans have volunteered to be in uniform, bear arms, and place themselves in harm's way to protect American interests. Their courage and willingness to fight for this country is reflected in the black granite of the Vietnam Veterans Memorial, where one out of every 10 inscribed name is of Hispanic origin.

Hispanic veterans like all veterans have made the supreme sacrifice and faced peril in the line of duty. They have done so without regard to ethnic heritage.

This afternoon I will describe programs in which the Veterans Employment and Training Service, the agency I head, assists Hispanic veterans by serving all veterans.

The local veterans employment representative and Disabled Veterans Outreach Program fund about 3,000 positions that provide veterans with employment assistance in over 1,700 locations

throughout the Nation. Together these programs ensure that veterans receive labor exchange information and referrals to job openings and other employment related services. Of the 1.8 million veterans who registered with these two programs last year, 114,000 were Hispanic veterans. Over half a million of all veterans who registered were helped into jobs.

VETS also administers grants funded under Title IV, part C, of the Job Training Partnership Act. Through this program we periodically fund demonstration projects that explore different program designs and strategies that may improve the delivery of employment and training services to veterans who are encumbered with exceptional barriers to employment.

In 1988, the American GI Forum operated a grant that was very successful in providing separating minority women veterans with training and employment. At about the same time, the American GI Forum also operated a veterans whole family program that provided a rich mixture of counseling, training and employment assistance to Hispanic and other minority veterans and their spouses and children. We found that this holistic approach provides long-term benefits in terms of job retention and family stability.

Because of the successes in these demonstration pilots, current grants in this program, which will serve 7,000 veterans, are making a special emphasis to target services to minority and women veterans.

We have also applied some of the insight gained in the veterans whole family concept through the Transition Assistance Program where both veterans and their spouses are being served. Now, this program, more commonly referred to as TAP, instructs separating military men and women on how to find civilian employment. Last year, TAP trained 145,000 service members, and based on our enrollment to date another 160,000 will have been trained by the end of this fiscal year, which is just about over.

Service members who participate in TAP workshops find employment sooner than those nonparticipating counterparts. Based on this success, TAP is vital to the employment potential of every separating service member.

While the current unemployment rate for recently separated veterans is 3.8 percent among Hispanic veterans, in this category it is 10.6 percent. We believe that the first step in ameliorating the high unemployment rates among these young veterans is to maximize their opportunities for participation in the TAP workshops. I have implemented initiatives to this end in fiscal year 1995 we hope to see participation in this program increase by 14 percent.

The overall unemployment rate among Hispanic veterans is 8 percent. This rate is higher than that found among all veterans, which is 5.8 percent. This statistic is evidence of our need to direct more of our primary resources, the DVOP and LVER staff, where the veterans who are most in need.

Secretary Reich and I are committed to assuring that Hispanic veterans as well as all veterans succeed in the civilian work force. We are especially concerned with the relatively high levels of unemployment among Hispanic veterans. We believe that expanding the TAP program and directing more DVOP and LVER resources

to serve veterans who have significant barriers to employment will increase employment opportunities for our Hispanic veterans.

Thank you for this opportunity to describe some of VETS employment and training services and our concerns and plans regarding the employment of Hispanic veterans. I would be happy to answer any questions you might have.

[The prepared statement of Mr. Taylor appears at p. 135.]

Mr. EVANS. Thank you. Mr. Bechet.

STATEMENT OF LEON BECHET

Mr. BECHET. Mr. Chairman, and members of the committee, I would like to thank you for the opportunity and privilege to appear before you during Hispanic Heritage Month to address the topic that is in discussion today. My name is Leon Bechet. I am the Assistant Administrator for Veterans Affairs at the Small Business Administration.

Mr. Chairman, I would like to ask that my complete statement be made a part of the record.

Mr. EVANS. Without objection, so ordered.

Mr. BECHET. Thank you. The Small Business Administration's veterans program was begun as a result of the congressional mandate that SBA give special consideration to veterans, their dependents and survivors. Based on that mandate the Office of Veterans Affairs was established on May 14, 1982.

During our almost 13 years of existence we have worked closely with the veterans' service organizations and the SBA field and program offices to reach out to veterans who have honorably served our country and who are interested in entrepreneurship. With the current base closings and military downsizing our services will continue to be valuable to our Nation's veterans.

As the committee is aware, the SBA offers a number of programs to help small businesses, and all of our programs are available to any veteran who meets the program qualifications. SBA's principal loan program is known as the 7(a) loan guaranty program. Loans under this program are made by commercial lending institutions and guaranteed by the Small Business Administration. In fiscal year 1994 the SBA expects to make approximately \$7.6 billion of 7(a) loans.

Where funds are available the SBA also makes direct loans to businesses that cannot obtain funds elsewhere on reasonable terms. Traditionally, the Congress has earmarked a portion of the SBA loan funds for direct loans to Vietnam era and disabled veterans.

In fiscal year 1994, as of September the 1st, the Vietnam era and disabled veteran loan program amounted to a \$12 million veteran loan program. Although there are no provisions in the fiscal year 1995 Appropriation Act for a continuation of this program, we intend to meet the needs of our veteran constituency by renewed emphasis on bank loans to veterans and by leveraging the guaranty funds available to expand the veteran guaranty loan program to a \$1.7 billion program. Currently, the veteran guaranty loan program makes \$1.2 billion of loans per year.

Mr. Chairman, you have indicated your interest in data regarding our loan programs and Hispanic veterans. First, the Census

Bureau reports that there are over 422,000 Hispanic American-owned small businesses in the United States; 17.5 percent of these, or almost 74,000, are owned by Hispanic American veterans.

During the current fiscal year we have made 2154 loans to Hispanic Americans, totaling more than \$384 million, utilizing our 7(a) loan program. This figure has more than doubled from the \$170 million total in fiscal year 1991. Hispanic veterans received 245 7(a) loans totaling \$44 million in fiscal year 1994, and I might mention that that is the figure as of September the 1st. The figures for the year end will probably add to more than that.

The Small Business Administration also administers a development company program. We approved \$51 million in development company loans for Hispanic firms during fiscal year 1994. This figure also is up 14 million from fiscal year 1991. Hispanic American veterans received \$2.3 million in development company loans in fiscal year 1994.

My office, the Office of Veterans Affairs, devotes much of its efforts to outreach for veterans. We want to assist veterans to understand and utilize all of SBA's programs. In addition to SBA specific programs my office has developed outreach and training programs just for veterans.

One of these is the veterans entrepreneurial training program. In this program we provided indepth business training to veterans and/or their spouses. Currently there are two programs, two veteran entrepreneurial training programs in operation. One of them is being conducted in New York by the Veterans Leadership Program, and the other is being conducted at Central State University in Wilberforce, OH.

We also are involved in business opportunity conferences, and the Transition Assistance Program, and I might mention that the Assistant Secretary of Labor for Veteran Employment and Training and I have been working closely together, and, as a matter of fact, with his cooperation we have managed to insert a chapter in the Transition Assistance Program manual, the TAP manual, dealing with SBA services and how people separating from the military can access SBA's services.

We are also involved in defense technology seminars wherein we work with the Naval Surface Warfare Center and the Army research laboratories to provide technology to veteran-owned small businesses that are interested in this field.

Further, Mr. Chairman, more than 50,000 Hispanic Americans utilized the training and counseling service of the Service Corps of Retired Executives' Small Business Development Centers, and SBA's other resource partners during this fiscal year.

We also administer a Minority Enterprise Development Program, the 8(a) program. There are 5433 firms in the SBA's 8(a) portfolio. Of these, 1369 are owned by Hispanic Americans. Thus Hispanic-American owned firms make up 25 percent of the SBA's 8(a) portfolio.

With regard to defense conversion, we are working with the Department of Defense currently to provide assistance to firms affected by defense downsizing. The Congress has already appropriated \$3.5 million for management and technical assistance for

these firms through the SBA's small business development program.

Mr. Chairman, I was privileged to participate in the American GI Forum convention last August, and have been working closely with Mr. Antonio Gil Morales, who is the National Executive Secretary, to provide even more input into future conventions and future meetings held by the American GI Forum.

Mr. Chairman, I hope this information is helpful to your committee. The SBA is dedicated to helping small businesses grow and prosper. Through our special outreach programs for veterans, our goal is to assist every qualified veteran utilize all of the SBA's resources and programs to develop successful businesses and provide jobs for other veterans.

Thank you for the opportunity to testify. I would be pleased to respond to any questions you may have.

[The prepared statement of Mr. Bechet appears at p. 139.]

Mr. EVANS. Mr. Bechet, have you looked at the problems that minority-owned businesses are having with graduating from the 8(a) program?

Mr. BECHET. Sir, I have not specifically looked into that myself. I do understand that that division of SBA, the Government Contracting Minority Enterprise Development Section, is doing a lot of work in that area currently, and as a matter of fact, they are coming up with something of a revision of that program. I am not familiar with all the details, but I can furnish it to the committee if the chairman wishes.

Mr. EVANS. I appreciate your working in that regard. It is a problem in my own congressional district where an 8(a) develops expertise in an area and they graduate from the program, but the system or the contract that they deal with doesn't graduate with them. This translates out in the rest of the marketing, you might say, for bidding and it prevents them from even bidding on that contract after they have developed that expertise.

In a statement submitted by the Vietnam Veterans of America for this hearing they testify that "a succession of SBA Administrators have demonstrated an inconsistent commitment and failure to implement statutory requirements," that veterans be given "special consideration" in their applications for loans or loan guarantees.

Could you respond to that?

Mr. BECHET. To the best of my knowledge, Mr. Chairman, as far as loan applications are concerned the special consideration involved is that the veteran applications that are received by SBA for processing are placed before other applications received on the same day. There are a few exceptions to that because SBA has certain obligations to the preferred lenders and the certified lenders, and under that program they have to give the lender a response within a given period of time. But aside from that one—or those two exceptions, I should say, veterans do receive priority as far as processing is concerned.

On the other hand, you have the basic requirements of credit that are applied to all loans across the board, and there is really nothing special in considering the veteran's application. Ahead of that we do try to the best of our ability to assist the veterans in putting together their loan applications and their loan packages so

that they can develop a complete package that doesn't need any additional information and can be rapidly processed by the loan processing officer.

Mr. EVANS. Can you give us the statistics for the past year of the veterans that have received special consideration?

Mr. BECHET. Well, sir, basically to the best of my knowledge all of them did. All of the loan applications were treated in this manner with the exception of the preferred lending program and the certified lenders program.

Mr. EVANS. I have some additional questions, but in the interest of time I will submit them for the record, and your answers to them and the questions themselves will be made part of the record.

(See p. 291.)

Mr. EVANS. The Congressman from Texas.

Mr. TEJEDA. Thank you, Mr. Chairman.

And certainly I appreciate your testimony, Mr. Bechet. You were very precise in some of the figures that you cited in terms of the amount of dollars that were loaned and made available to Hispanic veterans, and certainly that is a success.

But do we have a total figure in which to gauge that in terms of 100 applications came in, 20 were approved? Do you have those figures available or can you make them available to the committee?

Mr. BECHET. I can make them available to the committee.

Mr. TEJEDA. Do you see what I am getting at?

Mr. BECHET. Yes, sir.

Mr. TEJEDA. In other words, if we make \$200 million worth of loans, that is great. However, were there, you know, \$500 million worth of applications that were put in by Hispanic veterans? And I am just wondering, if only X percentage were approved why were the other, whether it is 90 percent or 80 or 50 percent, or whatever the figure may be, what were the main causes or reasons for their not being approved and what can we do to help them and assist them for next time they apply?

Mr. BECHET. We can furnish you with information on the direct loans that were turned down. Now, unfortunately, as far as guaranty loans, the person applies to the bank and we have no way of knowing if that application is not submitted to us. But I will be glad to furnish that for the record.

Mr. TEJEDA. Thank you very much.

Also, Mr. Taylor, welcome, and thank you for your testimony.

You heard some of the questions that I asked some of the previous panels in terms of coordination between agencies and departments and the VA. Your Department currently administers the McKinney Act funds for homeless veterans. What do you see in future years for this program, or what do you see in the immediate future for the McKinney Act funds for homeless veterans?

Mr. TAYLOR. I am delighted you asked me that question. We have the responsibility for a program that is known as the homeless veterans reintegration program—HVRP. Three years ago we were only authorized and appropriated \$1.3 million for this program. Last year we received 5 million, and with that money we were able to find jobs for 4,000 homeless veterans.

We received the same amount for fiscal year 1994. We expect that about the same number of homeless veterans will be found jobs in this current fiscal year. Fiscal year 1995 is the same.

We have just submitted our fiscal year 1996 budget to the Secretary and we are asking for more money for homeless veterans. My position is that we know there are more than 250,000 homeless veterans. I believe it is closer to 280,000 homeless veterans that are out there. My position is that they are not all suffering from PTSD and not all are alcoholics. A lot of them have just fallen on hard times and just need some help in finding a decent job. And with the proper amount of resources, we think we can help many, many thousands of these homeless veterans. So, I believe Secretary Reich will support my request.

We need to develop a stronger relationship with the VA. We have a good relationship with the VA, especially in the SMOCTA area and other areas as well. We have a very good relationship with DOD in the TAP program area. But we need to strengthen our relationship in regard to how we help the homeless. Finding shelter for them is okay. But I think what they really need, those that are job ready, is a job to come out of those shelters and become taxpayers just like the rest of us.

Mr. TEJEDA. You mentioned your relationship with the VA. Let me ask you, HUD, Housing and Urban Development, has programs for the homelessness. I don't know if they specifically have programs for homeless who are veterans.

Are you aware of that? Or what type of contact and/or coordination do you have with HUD in terms of homelessness?

Mr. TAYLOR. I have begun to reach out to HUD. We have had some preliminary discussions with the Assistant Secretary's deputy, on this very issue. And the dialogue is continuing.

I am hopeful that we can find ways and means in which we can develop a partnership whereby more resources will be made available to us so that we can provide more jobs for homeless veterans.

Working closely with the VA and hopefully HUD along with the Department of Labor is a win-win-win situation for all of us. The Departments win because they are doing good work to help veterans. And of course, the ultimate winners are the veterans.

Mr. TEJEDA. You know in his reinventing government and streamlining government I know that Vice President Gore and others oftentimes one would have to go to, well, it was SBA as a matter of fact. You are probably very familiar with this, Mr. Bechet. That there were forms and forms and forms to fill out, and I believe they streamlined it to maybe one form. And that a person would get an answer maybe in 3 days, I believe, which is very commendable and to be applauded.

But, I am concerned about the veterans, you know, the Mr. Riveras and the Mr. Rodriguezes and the Mr. Zamoras and the Mr. Martinezs who are in on the front lines and in the trenches, and in their quest, in their effort to help veterans they look to HUD, they look to Labor, they look to SBA, they look to VA, they look to the States, they look all over the place in doing their job as best as they can.

The reason for bringing this up about coordinating it or bringing it together, streamlining, making it easier—I am not talking about

cutting back monies. As a matter of fact, more resources are needed. What I am talking about is making it easier for the veteran out there and for the workers in the front lines who are trying to assist veterans, making it easier for them to get a comprehensive package together, whether it is from SBA or from HUD for the homeless and from Labor for the homeless.

And keep in mind, again I reiterate, I am not saying that in streamlining and in bringing it together through coordination is cutting back on resources. We need more resources. But at the same time I think we need to make it more accessible and more available to the veterans.

Mr. TAYLOR. In the JTPA grant area we have just reinvented that process.

Prior to the reinvention effort we were saddled with very cumbersome paperwork, a very busy kind of situation. Thirty, forty States would send in their proposals and the result would be very small grants, hardly worth the effort.

And so we decided that we would survey the States and ask them how we could improve this process. The bottom line is we improved it. The grants are much, much larger now, and the States are coming back and telling us they are very happy that we reinvented this process. The JTPA IV-C process manual was this thick. We reinvented it. It is now about that thick and everyone seems to be extremely happy about it.

Mr. TEJEDA. I would hope that is done in all other projects, particularly for the homeless. And again, we need coordination. We need—the left hand needs to know what the right hand is doing, because I think if we do have that then we can make it more accessible and more available for our veterans, and particularly for those individuals who are out there on the front lines and trying to help our veterans.

Thank you, Mr. Chairman.

Mr. EVANS. Thank you. And we thank this panel. With your testimony we conclude this hearing.

As we noted at the outset we hope that this is the beginning of a process of opening the door to Hispanic American veterans. We look forward to working with you in the future and holding a hearing again next year.

We invite all of you to join us in room 340 for lunch with the VA.

Thank you all very much. And we appreciate your time and attendance.

[The prepared statement of the Vietnam Veterans of America appears on p. 145.]

[Whereupon, at 12:35 p.m., the subcommittee was adjourned.]

APPENDIX

Honorable Lane Evans, Chairman
Subcommittee on Oversight & Investigations

Committee on Veterans' Affairs
U.S. House of Representatives

Hispanic Veterans: Contributions to the Nation and Community,
VA Benefits and Services and Related Issues

September 28, 1994

Good morning and welcome. During Hispanic Heritage month, it is particularly appropriate for the Subcommittee on Oversight and Investigations to meet this morning to conduct a public hearing on "Hispanic Veterans: Contributions to the Nation and Community, VA Benefits and Services and Related Issues".

Hispanic men and women are no strangers to military service. They have served with dignity, distinction and courage and have always been among the first to answer their country's call.

But while Hispanics have a long and proud tradition of military service, the story of Hispanic veterans is not well known.

In my own District, for example, there is Hero Street. A street which is most fittingly named.

After fleeing their homes during the Mexican Revolution, several families made their way to Silvis, Illinois. In Silvis they began building new lives on Second Street, which was a block and a half long.

As children, the boys and girls of Second Street felt the sting of discrimination and social injustice. But they were also taught by their families that their street, their country and the ideals for which it stood were worth fighting for and defending.

During the last 50 years, over 100 young Hispanic men and women from this small community have answered our country's call and proudly served in the Armed Forces. Among their numbers, eight have made the ultimate sacrifice defending our freedoms and our liberty.

To honor their memory and in recognition of this remarkable record of service and sacrifice, Second Street is now known as Hero Street. The extraordinary patriotism and self-sacrifice of these otherwise ordinary Americans, will never be forgotten.

Hero Street and the Hero Street Monument should be considered a National Memorial. They well represent the selfless contributions and most heroic sacrifices of all Hispanic Americans who have served in our Armed Forces.

Today, the Subcommittee begins a process of gathering information and shedding light on the military service of Hispanic veterans. The Chair hopes this hearing will be the first, but not the last, step in recognizing the contributions of Hispanic veterans to our Armed Forces and the opportunities and challenges which are found in civilian life after separation from military service.

Many people have assisted the Subcommittee prepare for today's hearing, but the contributions of a few individuals are particularly noteworthy. The Chair gratefully recognizes and acknowledges with thanks Congressman Luis Gutierrez and Congressman Frank Tejeda and the members of their staffs for their special contributions to this hearing.

The Subcommittee is scheduled to receive testimony this morning from many individuals and looks forward to the contribution each witness will make. Without objection, the complete prepared statement submitted by each witness will be included in its entirety in the printed record of this hearing. Each witness will be recognized for five minutes to make an oral presentation and witnesses are again requested to summarize from their prepared statement as needed to limit their presentation to five minutes.

The Chair is particularly pleased to recognize and welcome those in attendance today who are not Members of the Veterans Affairs Committee. Carlos Romero-Barcelo is the Resident Commissioner from the Commonwealth of Puerto Rico and Congressman Solomon Ortiz represents the Twenty-Seventh (27th) District of Texas. Your attendance today is most appreciated by the Subcommittee and is a clear demonstration of your personal interest in the issues to be examined this morning.

The Chair also notes Congressman Henry B. Gonzalez of Texas, the Chairman of the House Committee on Banking, Finance and Urban Affairs, and Congressman Lincoln Diaz-Balart of Florida have submitted written testimony for today's hearing. Although they are unable to be present today because of prior obligations, both Members have provided the Subcommittee with copies of their statement which has been made available to the public. Both statements will be included in their entirety in the record, without objection. We appreciate these important contributions to today's hearing.

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OPENING REMARKS

before

House Veterans Affairs Committee
Oversight & Investigations Subcommittee

REP TERRY EVERETT

September 28, 1994

MR. CHAIRMAN, I THANK YOU AND THE DISTINGUISHED RANKING MEMBER, MR. RIDGE, FOR YOUR LEADERSHIP IN HOLDING THIS HEARING ON THE NEEDS OF THE MORE THAN ONE MILLION HISPANIC VETERANS IN THIS COUNTRY. I WANT TO WELCOME ALL OF OUR WITNESSES THIS MORNING. WE APPRECIATE YOUR BEING HERE.

THERE IS NO QUESTION ABOUT THE IMPORTANCE OF THE SACRIFICES AND SIGNIFICANT CONTRIBUTIONS MADE BY HISPANIC AMERICANS TO THE PRESERVATION OF FREEDOM AND IT IS HELPFUL FOR THIS COMMITTEE TO HEAR FROM YOU ABOUT YOUR SPECIFIC NEEDS AND CONCERNS.

THANK YOU FOR BEING HERE WITH US TODAY AND WE LOOK FORWARD TO YOUR TESTIMONY.

THANK YOU AGAIN, MR. CHAIRMAN.

Statement of Representative Henry B. Gonzalez
September 28, 1994

"Hispanic Veterans: Contributions to the Nation and Community"

Mr. Chairman and Committee Members, I very much appreciate this opportunity to testify on behalf of Hispanic Veterans. I commend you for holding this hearing and for bringing attention to the unparalleled contribution of Hispanics in the field of military service. No other group has been represented so heavily, in proportion to its numbers, as Hispanics. In my experience, being from South Texas, most Hispanics in my congressional district and the surrounding area are of Mexican ancestry. Indeed, in the Korean War, more Mexican-Americans were awarded the Congressional Medal of Honor, in proportion to their numbers, than any other group.

Residing in my congressional district in San Antonio are over 60,000 veterans, accounting for more than 10% of my constituents. These veterans received nearly \$76 million in total VA benefits in fiscal year 1993. Most of these veterans are of Mexican ancestry. Texas has the highest percentage of veterans who are Hispanic, and the second highest (to California) overall number of Hispanic veterans.

But accompanying the tradition of military service among Hispanics, and despite their many contributions and sacrifices, there have been many battles against discrimination both inside and outside of the armed forces. It was not so long ago when the discrimination was very blatant. I remember in 1947 when the father of a young Hispanic veteran who had just returned from serving in World War II came to me. With the little money he had saved, the young serviceman had bought a house. But there was a cloud on the title to the house because the land where the subdivision was located had belonged to a Ku Klux Klansman and every deed contained a restrictive covenant requiring that the deed revert to the original grantor if it was ever conveyed to a Mexican or a Black. I organized the Mexican-American community in San Antonio to join in the lawsuit then pending before the U.S. Supreme Court which involved a challenged by Blacks in St. Louis to restrictive covenants. We won, and on the basis of the

Supreme Court's ruling the serviceman whose father had approached me was able to keep his home.

But what kind of a "welcome home" had this been for a man who had risked his life in war on behalf of his country? He had the right to die for his country, but he had been denied the right to live wherever he wanted. Hispanics returning from service often found they were denied public service and public accommodations, and their employment rights were at least limited if not outright denied.

Today, discrimination toward Hispanics is, perhaps, not as blatant as it once was, but whenever equal economic opportunity is denied it is the most insidious form of discrimination because it prevents a person from being able to better his economic standing, to live wherever he wants and buy a better house, and to have the power and control over his life that comes with financial security.

And Hispanics still face many barriers - even within the military, even today. One barrier, for instance, is an issue I fought last year and on which I have thus far been unsuccessful. Many upper-level military jobs require security clearance; yet, U.S. policy denies security clearance to all whose parents are not U.S. citizens. This policy has a disproportionate and very discriminatory impact on Hispanic service members. I cannot see any connection between the citizenship of one's parents and one's own ability and inclination to be totally loyal to the United States. I remember clearly a time when much concern was expressed that our first Catholic President would have primary loyalty to the Pope rather than to the United States - a concern that was soon dispelled. I also remember clearly in my own experience a criticism, which in fact surfaces occasionally even today, that because I am of Mexican ancestry or because my parents were born in Mexico, that I would have loyalties to Mexico that would surpass my loyalty to the United States. My record in public service absolutely proves the fallacy in this argument.

Incredibly, when a constituent approached me last year and told me he had been denied security clearance solely because his parents are not U.S. citizens, I was told that such a denial is not an "adverse action" and does not constitute any reflection upon his

loyalty. That is so outrageous a statement that it is incomprehensible - how can a denial of clearance, which indicates a person is not completely trustworthy, not be an adverse action and a reflection upon loyalty?

Although military service has enabled many Hispanics, most of whom have been poor or low-income, to get training, to become educated, and to move solidly into the middle economic class, clearly there is a significant amount of progress that still needs to be made for Hispanics to be accorded full rights and opportunities in the armed forces.

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**TESTIMONY SUBMITTED BY
REPRESENTATIVE SOLOMON P. ORTIZ
BEFORE
THE SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS
COMMITTEE ON VETERANS' AFFAIRS
SEPTEMBER 28, 1994**

Mr. Chairman and Members of the Subcommittee, thank you for this opportunity to present testimony concerning the contributions and concerns of Hispanic veterans. As a veteran, I am pleased to advocate the concerns of the veterans in South Texas, and across the country.

Veterans are one of the most important national resources in our country, and it is always a privilege to hear the wisdom and learn about the needs of so many brave men and women who have served this great country with distinction and honor. In particular, I am pleased to discuss the successes and needs of Hispanic veterans. As with all veterans, Hispanic veterans have been asked, and have been willing, to sacrifice their all for this country in the name of liberty, independence and freedom. These veterans have served their country honorably and have been willing to pay the ultimate sacrifice; their blood for our freedom.

Hispanic veterans, which number over 925,000, are a substantial element of the veterans community in the United States. The military service of Hispanics reflects their belief in the United States. In fact, the participation of Hispanic veterans can be traced back to the Revolutionary War, and later the Civil War, where Hispanics served in both the Union Army and the Confederate Force. Hispanics also served in the Spanish-American War in 1898, specifically as members of Theodore Roosevelt's "Rough Riders." While there is no exact documentation of the number of Hispanics who participated in World War I, we do know that they served with great honor. Estimates for World War II show 250,000 to 500,000 Hispanics who contributed to the allied effort on behalf of the United States. With our country's involvement in Korea, Vietnam, Lebanon, Panama, Iraq, and the Persian Gulf, the numbers of Hispanic veterans and their military involvement increased. We should all thank these Hispanic veterans for the liberty we enjoy, and thank them for their part in defending it.

Hispanics have made an investment in our Armed Services, and they deserve to be recognized for their valor. They also deserve the services and treatment that all other veterans receive. It is important that the Department of Veterans Affairs (VA) continue to improve its outreach to Hispanic veterans. VA should have bilingual representatives at VA medical facilities, and they should print VA announcements in Spanish. Additionally, it is important that Hispanic veterans have access to medical care. For example, in my congressional district, outpatient care is available fairly near to hand, but care requiring special services or hospitalization is available only by traveling five hours to San Antonio.

Again, it is my pleasure to pay tribute to Hispanic veterans - veterans who placed themselves in harm's way so that this country might remain strong and free. As Members of Congress, we must make sure that these veterans are appropriately honored and respected by their government. The active duty service of many Hispanic veterans may be over, but the wounds of war remain, and we should pay careful attention to their concerns.

I admire you; I respect you; and I salute all Hispanic veterans.

STATEMENT BY CONGRESSMAN LINCOLN DIAZ-BALART (FL)
BEFORE THE SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS
OF THE COMMITTEE ON VETERANS' AFFAIRS

HISPANIC VETERANS: CONTRIBUTIONS TO THE NATION
AND COMMUNITY, RECEIPT OF FEDERAL BENEFITS
AND RELATED ISSUES

SEPTEMBER 28, 1994

Thank you, Chairman Evans and Ranking Member Ridge, for holding this hearing. I appreciate the opportunity to participate in what I am certain will be an informative hearing to look at the valuable contributions and specific concerns of Hispanic veterans in our nation. I am a strong advocate of our nation's veterans and believe that serving in the military demonstrates the highest form of service one can offer his or her country. Those who fought and died in defense of democracy will be forever remembered and revered.

Throughout the history of this country there have been hundreds of thousands of soldiers from many Latin countries who have fought for the U.S., yet the historical data detailing these brave veterans is very sketchy. Hispanics of many nationalities, including those from Cuba, Mexico, Spain, Puerto Rico, Central and South America participated in many armed conflicts, although statistics and biographical information such as country of birth were not maintained by our military until very recently. Cuban-Americans have joined the ranks of the U.S. military in increasing numbers, especially during the Cuban Missile Crisis, with roughly 30,000 Cuban-Americans joining our military since 1960. Because many Cuban-American members of our armed forces began as members of the Cuban military, many of them shun publicity and out of respect to their wishes, I will not discuss them. There have been many outstanding Cuban-American veterans and I would like to briefly mention just a few as a glimpse of their contributions to our nation's defense.

One organization that deals specifically with the concerns of Cuban-American veterans is the Miami-based Cuban-American Veterans Association (CAVA). Although most of its members are also members of the American Legion and Veterans of Foreign Wars,

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SEPTEMBER 28, 1994

CAVA was founded a few years ago to enable its members to express an opinion about Cuba since these other organizations focus mainly on American issues. There are members of CAVA from throughout the United States. The President of CAVA, Colonel Juan Armando Montes, was a pilot who fought valiantly for the United States in several conflicts, including Vietnam. Another daring pilot, Felix Rodriguez, the author and subject of a book entitled The Shadow Warrior, was reportedly the last person alive with the Argentine mercenary Che Guevara.

Also among the ranks of Cuban-born officers in the U.S. military is Mercedes Cubria, who was our nation's first female Hispanic officer. Born in Cuba, Ms. Cubria joined the Women's Army Corps during World War II, and assisted the United States during the Missile Crisis in 1962. For her valuable intelligence work, Ms. Cubria was awarded a Bronze Star.

Another veteran I would like to mention is Jacinto Acebal, a soldier who is one of the most highly decorated veterans of the Vietnam War. Mr. Acebal, a Miami postal supervisor, was a machine-gunner and helicopter crew chief who flew over 500 hours of combat and rescue missions and waited almost 20 years after returning from the war to claim his medals. Apparently, although proud of his tour of Southeast Asia, Mr. Acebal was so discouraged by the lack of enthusiasm for the gallantry demonstrated by our forces in Vietnam that it wasn't until he visited the newly dedicated Vietnam Veterans' Memorial wall in Washington that he was inspired to finally claim his 18 medals. With the assistance of then-Representative Claude Pepper to expedite the process, Mr. Acebal was awarded the Air Medal with 11 clusters, the Rifle Badge, Crew Chief Wings, the Army Commendation Medal, the Good Conduct Medal, the National Service Medal and a unit citation for valor from the Republic of Vietnam.

I believe that these Cuban-Americans are typical of the brave Hispanic soldiers who fought for the United States. Patriotic loyalty, heroism, and dedication to the defense of our nation are principles exemplified by these courageous Cuban-

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Americans and I am proud that they are part of this country's veteran heritage. Again, thank you for this opportunity to testify and I look forward to reviewing the testimony from this important hearing.

TESTIMONY ON HISPANIC VETERANS
before the
SUB-COMMITTEE ON OVERSIGHT AND INVESTIGATIONS

by
JAKE ALARID
National Commander
American GI Forum of the U.S.

Good Morning. My name is Jake Alarid. I am honored to serve as the National Commander of the American GI Forum of the U.S., the nation's largest and oldest Hispanic Veterans organization in the country.

I appreciate the opportunity to come before this committee on this historical occasion that marks the first time ever that a Congressional committee listens to the problems, the needs, and the views of Hispanic veterans.

Americans of Hispanic descent have honored us throughout the history of this great nation of ours with valiant service in defense of our country. It is widely known that on a per capita basis the Hispanics have received more Medals of Honor than any other ethnic or racial group in the history of the U.S. Unfortunately, our brave men have also borne disproportionate rates of combat casualties because of their prevalence for assignment to "grunt" service.

Exalting the proven history and patriotism of the Hispanics is an important part of these hearings. However, I believe we can best honor their service by speaking to those issues for which they have so gallantly fought: equality for all of our citizens, freedom to pursue the American dream, and the honor of receiving the respect as "equal" Americans.

It is my duty to report to this Committee that these benefits, generally perceived to be available to everyone, have eluded some Hispanic veterans when it relates to their entitlements. This is not a condemnation of the Department of Veterans Affairs, Department of Labor, or other units serving veterans. It is an alarm ringing attention to the shortcomings of some of the programs and systems that mean well, but fall woefully short of reaching Hispanic veterans. It is also time to recognize the unique aspects that actually exist for Hispanic veterans.

Given the time allotted it is not possible to cover all problem areas at this session. Perhaps this committee will grant us periodic opportunities to continue this dialogue.

In today's testimony, I wish to address five distinct areas of priority need. These include the issues of Post Traumatic Stress Disorder that affects Hispanics at a higher prevalence rate than any other group of veterans; the area of employment and training for Hispanic Veterans that continues to be a problem; the homeless veterans issue that includes a "hidden homeless" element of Hispanic veterans; also, the issue of accessibility for Hispanic veterans who for some reason continue to apply for assistance at a much lower rate than other veterans; and finally, the absence of data in virtually all departments of government thus making it difficult to substantiate the lack of service to Hispanic veterans that is apparent to us based on anecdotal evidence.

Let me begin by discussing the issue of Post Traumatic Stress Disorder in Hispanic Vietnam veterans. Hispanic Americans have a long, proud and distinguished tradition of service in the U.S. Armed Forces. Hispanic Americans have historically served in numbers which far exceed their representation in the population of the United States.

However, such willing and stalwart service by Hispanic Americans has not been without a price. One of the paramount concerns of the American GI Forum of the United States is the fact that the National Vietnam Veterans Readjustment Study (NVVRS) found that the prevalence rate for current post-traumatic stress disorder (PTSD) was significantly higher among Hispanic male veterans of the Vietnam theater at an astounding 27.9 percent. Black and "white/other" male theater veterans had rates of 20.6 percent and 13.7 percent, respectively. Also, the NVVRS researchers specifically recommended further studies to answer the question: "*What characteristics account for the apparently greater vulnerability to PTSD among Hispanic theater veterans?*"

The courageous Hispanic veterans who suffer from PTSD, and their families, deserve an answer to this question. The American GI Forum of the United States adamantly recommends that Congress authorize and direct the Department of Veterans Affairs to conduct clinical and research studies of PTSD, and other stress-related psychological problems stemming from combat, in Hispanic Vietnam veterans. Specially designated funds should be allocated to finance this research.

It should be noted that Public Laws 101-144 and 101-507 mandate the National Center for PTSD conduct an epidemiologic study of PTSD in Native American, Native Hawaiian and Asian Pacific Islander Vietnam veterans, the "Matasunga Study." The American GI Forum recommends that Congress appropriate funds necessary for the VA to apply the methodologies developed in the Matasunga Study to design more ethnically sensitive and, therefore, better assessment tools, diagnostic strategies, and treatment approaches.

The American GI Forum of the United States recognizes the vital role that the VA's Readjustment Counseling Service (RCS) and the RCS "Vet Centers" have played in providing treatment of post traumatic stress disorder and related readjustment difficulties of war veterans. The Vet Centers have also assumed additional and essential responsibilities in the areas of homelessness, sexual trauma counseling, suicide prevention, alcohol and substance abuse, the physically disabled veteran, and minority veterans.

The Vet Centers have been quite successful in providing outreach service to minority veterans with PTSD and related readjustment problems. The success of the Vet Centers in providing services to minority veterans is undoubtedly attributable to counselors and team leaders who are veterans and representative of the minority veterans population.

The American GI Forum contends that the unparalleled staffing of the Vet Centers has in large part been through the untiring efforts of dedicated and long-time RCS management employees such as Dr. Gustavo Martinez, Acting RCS Director, and Dr. Alfonso Bates, RCS Regional Manager for Western Mountain Region 4A and Chief Clinical Director-West.

However, in spite of the demonstrable record of success of the RCS and its Vet Centers, VA studies and anecdotal evidence show that the Hispanic veterans population continues to be underserved. Thus, the American GI Forum of the United States recommends that Congress require the RCS's outreach be expanded and enhanced to include aggressive and innovative outreach programs for Hispanic veterans. The American GI Forum further recommends that Congress appropriate and specifically designate resources necessary for the RCS to accomplish this task.

The VA has established specialized programs for the treatment of veterans suffering from PTSD. These programs provide a continuum of care ranging from intense, long-term inpatient treatment to specialized outpatient care. However, VA's specialized PTSD programs are operating at or beyond capacity and, except for Vet Centers, waiting lists exist, particularly for inpatient services.

The American GI Forum of the United States recommends that Congress authorize and appropriate funds necessary for the VA to provide a level of service which accurately reflects the needs of Hispanic veterans for specialized PTSD inpatient and outpatient treatment programs and dual-diagnosis programs.

The American GI Forum of the United States believes that RCS's staff of racial and ethnic minority veteran counselors and team leaders would significantly decrease to typical VA staffing levels if the existing RCS "centralized-line-authority" organization (clinical and administrative line authority from VA Central Office through Regional Manger to Vet Center) is changed. Quite frankly, if RCS regional managers are eliminated and/or RCS Vet Centers are managed by medical centers as proposed by some, it is our belief that funding for Vet Centers would once again be redirected to other VA Medical Center programs at the discretion of VAMC management. The elimination of RCS regional managers would have a deleterious effect on staffing Vet Centers with qualified minority war veteran counselors and team leaders.

The American GI Forum of the United States recommends that Congress establish the Readjustment Counseling Service as a statutory organization within the Veterans Health Service. The VA should be required to provide notice to Congress before changing the existing RCS structure and organization.

Employment and training services is another critical area of concern for Hispanic veterans. The unemployment rate for Hispanic veterans and other minority veterans continues to be higher than that of white veterans. The Bureau of Labor Statistics reports that Hispanic veterans have an unemployment rate in excess of 8%.² That in-and-of itself is a critical issue, but the American GI Forum also believes that many other Hispanic veterans are chronically underemployed. Unfortunately, educational deficiency is a major factor in this problem. Twenty-eight percent of Hispanic male veterans did not graduate from high school and an additional 28% have only a high school diploma. Combined, this 56% majority of the Hispanic veteran population is limited in their job preparation.

These percentages become even more significant when one correlates them to the young age of the Hispanic veteran population. Twenty percent of Hispanic veterans are under age 35 and forty-seven percent are under age 44, as compared to twenty-eight percent of the white veterans.³ Our concern is that this young population of veterans, many of whom went into the military unskilled and educationally deficient and left the service much the same way, are now lost in unskilled positions promoting constant drift in and out of employment.

In addressing this problem, the central issue for Hispanic and other veterans is the limited funds available for the Jobs Training Partnership Act (JTPA), the primary employment and training system in our country.

The Title IV, Part C section of JTPA sets aside specific funding for veteran programs. The amount available, however, is less than 1% of the total JTPA funding. That pittance is bad enough, but it gets worse when local job plans under JTPA fail to include veterans as a target group because of the misconception that veterans are being taken care of by the Title IV-C section. Our organization urges the U.S. Department of Labor to issue strong directives to all State Governors and all Private Industry Councils that administer JTPA funds to include veterans as a performance standard requirement for their local plans. Veterans make great employees if given the chance for equal training opportunity. This is especially critical for Hispanic veterans who generally served in combat specialties or non-skilled support roles during their military service. I urge this committee to support our call to the Department of Labor to mandate veterans as a JTPA performance requirement in the local job plans. This would be a fairly simple alteration to the JTPA; alternatively, Congress could amend the Jobs Training Partnership Act legislatively to assure service to veterans by including them as a measured performance evaluation goal for each local job plan against the local population of unemployed veterans.

Homeless veterans is another great concern to our organization, as it should be to most Americans. This great tragedy in our society is being addressed by many government agencies, social service organizations, and the veterans service organizations. For many Hispanic veterans, homelessness is a fluid state as they drift in and out of temporary arrangements between family members and friends. Within the Hispanic culture, the extended family is a common occurrence and generally includes an obligation to extend a helping hand. "Mi casa es su casa" meaning "My house is your home." The unfortunate side of this benevolent effort is that in many cases the host family is already economically disadvantaged and the added burden of supporting another mouth to feed puts the host family at-risk of becoming homeless themselves. The American GI Forum through our National Veterans Outreach Program that serves homeless veterans, is also witnessing an increasing number of homeless veterans families. Through our case-management we have seen the heartbreak of veterans dividing their children among family members. Homelessness for American veterans is an intolerable situation. I remind this committee that homelessness is not just individuals living in abandoned buildings and under bridges, but also includes a significant population of individuals in doubled-up situations, which includes many Hispanic veterans.

Our Homeless Veterans Reintegration Program experience has left us with some very clear impressions of the homeless veterans problem, and I would like to briefly share them with the

committee. While this tragedy afflicts veterans of all races and ethnic groups, our experience with the Hispanic homeless has shown that they respond best to environments sensitive to their cultural needs. This was especially true in our outreach efforts. Posters, flyers, brochures, and other public service announcements have served to make other agencies aware of the service we provide but the homeless veterans themselves responded more readily to direct and personal contact. Hispanic homeless, in particular, reacted more positively to the outreach efforts of other Hispanics.

In counseling sessions, this was also evident. In working with the homeless, counselors need to establish a connection with the participant. The homeless come in with an array of problems ranging from severe physical ailments to the very evident and sometimes overpowering need for a shower. By relying on the comfortable understanding of some cultural aspects common to the counselor and the participant, the counselors have been able to break through the distrust that is always present in the homeless.

The American GI Forum supports the continuation of programs targeting the homeless veterans as long as the problem persists. It is our further recommendation that veterans community based groups be utilized to reach out to their "lost brothers," and that the programs be comprehensive in design to address the array of problems each homeless veteran presents. The programs should not be short-term fixes that we will soon have to fix again. Instead, they should be programs that offer a continuum of care, maintaining a close case-management of the very fragile state of the recovering individuals. Homelessness for any American is intolerable; homelessness for veterans is a national embarrassment.

Another major issue facing our constituency is access to and the provision of health care for Hispanic veterans. It is important to note that Hispanic veterans are often characterized by limited resources. Also, many Hispanic veterans, while otherwise eligible for medical care, either cannot or will not travel to their local VA medical center. Further, consistent with the premise that Hispanic veterans have been over-represented as a percentage of wartime casualties, it has been reported that "over 30 percent of Hispanic Vietnam veterans reported having a VA certified service-connected disability" and that "sixteen percent [of Hispanic Vietnam veterans] relied on VA compensation as their primary source of income."⁴

However, notwithstanding the commitment and sacrifices of Hispanic veterans, the National Vietnam Veterans Readjustment Study data and other studies found that Hispanic veterans utilize VA and other health care services much less than White veterans or Black veterans. An illustrative example of such studies is the Furino & Munoz report that concludes: "A large number of Hispanics are military veterans and qualify for VA benefits, yet they underutilize the VA health services."⁵

The American GI Forum of the United States recommends that Congress authorize and direct the Department of Veterans Affairs to conduct a study to determine if VA health care facilities and PTSD resources are geographically located to provide for the treatment of Hispanic veterans, whether in underserved urban areas (such as the barrios of Los Angeles, California, Albuquerque, New Mexico, or Puerto Rico) or remote, rural areas such as the Lower Rio Grande Valley of Texas. The VA should be encouraged to use a wide range of innovative approaches for health care delivery and aggressive outreach (e.g., community-based clinics; staffing of VA health care facilities by Hispanic employees who are veterans and/or bilingual; provision of transportation) to improve access in those areas that have special problems for Hispanic veterans.

The American GI Forum of the United States recommends that the VA be encouraged to combine resources with the Department of Defense and the Department of Health and Human Services to improve access to Hispanic veterans in underserved areas. In remote areas where the veteran population is not sufficient to justify a VA health care facility, contracting for services and fee-basis care should be utilized to provide the full range of services to eligible Hispanic veterans.

In completing this testimony, I would like to focus attention on one common thread throughout my presentation and those of others coming before this committee today. That is, the permeating atmosphere of heresay and anecdotal evidence throughout much of our presentation.

Why? Because the government continues to fail our constituency in documenting Hispanics as a specific statistical measure in many of its reports. It is not that as Hispanics we are attempting to separate ourselves from others; we are merely trying to ascertain what is the factual state of service to Hispanic veterans. As you will hear today, there is a great deal of concern on many issues, and clearly we are a growing minority with a rising number of participants in the military forces. We must know factually where we stand in order to correct the problems.

For this reason the American GI Forum has asked for a GAO study on the status of Hispanic veterans. The initial request was made by Senator Orrin Hatch in a letter to the General Accounting Office in August 1992 in his capacity as Chairman of the Senate Task Force on Hispanic Affairs. The Congressional Hispanic Caucus was also requested to support this GAO study.

Unfortunately, to date GAO evidently continues to hold this request as a low priority initiative because nothing has been done on it. I present it to this committee in hopes that you, too, will join the call for GAO action on this study. How can we proceed with constructive initiatives on problems that we clearly sense in our community but cannot document? Lacking empirical data, it is impossible to prove causal or correlative relationships which affect many of the issues I have presented today. For example, is the higher rate of current prevalence of PTSD among Hispanic Vietnam veterans due simply to the fact that proportionately they were exposed more to combat situations than their counterparts? Or, is there a cultural element which causes this higher rate? Or, is some other factor at play here which has not yet been considered? Similar confusion reigns concerning the higher unemployment and underemployment of Hispanic veterans and underutilization of VA facilities. Without studies to determine causal and correlative relationships, effective strategies to address the specific needs of Hispanic veterans cannot be developed and implemented. We need help and that's what I'm asking of this committee.

I thank you for this opportunity and I strongly encourage you to continue your investigative initiative on behalf of Hispanic Veterans.

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REFERENCES

- 1 Kulka, R.A., Schlenger, W.E., Fairbank, J.S., Hough, R.L., Jordan, B.K., Marmar, C.R. & Weiss, D.S. (1990: 261). Trauma and the Vietnam War Generation. New York: Brunner/Mazel.
- 2 Bureau of Labor Statistics Monthly Survey of Select Households. August 1994.
- 3 Office of Policy and Planning (1993). Chief Minority Affairs Officer Report. Department of Veterans Affairs (p.41). Washington, DC: Secretary of Veterans Affairs.
- 4 Becerra, R.M. (1982, 173). The Hispanic Vietnam Veteran Mental Health Issues and Therapeutic Approaches. In R.M. Becerra, M. Karno & J.E. Escobar (Eds.). Mental Health and Hispanic Americans: Clinical Perspectives (pp. 169-180). New York: Grune & Stratton.
- 5 Furino, A. & Munoz, E. (1991). "Health Status Among Hispanics: Major Themes and New Priorities". Journal of the American Medical Association 265:255-257 (citing Department of Veterans Affairs Annual Report 1988, Washington, DC: Secretary of Veterans Affairs; 1989:89, 90, 98).

Mr. Chairman, Honorable Members of Congress , Distinguish Guests, and Fellow Comrades, it is with great pleasure that I address you with some historical memorabilia in words citing a few of the many accomplishments of the Portorican as a militia, defending the democratic principles of the world.

Searching through the historical record of the Portorican militia, we will discover and look into the sacrifices and love to our beloved country of those who served and the ones that still are doing so , and will do if needed in the future.

Just like the minute men that in the colonial days of this country answered the call to arms in order to protect and help mold the structure of our governmental system, the Portorican was also requested to bear arms almost five centuries ago by the Spanish First Governor of the island Don Juan Ponce De Leon.

The spirit of freedom resurged in the year of 1797 when Urban Militians and so-called volunteers Institute came to bear arms to repel a British attack on the island of Puerto Rico.

A distinguish motto expressing the alertness of the Puerto Rico State Guard is an indication of the standards of the units always ready to respond. Lt. Col. Luis A De Casanova in pages of history books, clearly denotes the well-deserved motto, "En Alerta" meaning always on alert.

After the Spanish-American War, the first Portorican was enlisted in the year 1899. Just one year after the United States historical landing on the shores of the island, a second Lt. commission was granted to a gentleman named Blas Nadal. Others followed almost six years later in the year 1905. Among them by name, Mr. Henry Rexarch, Pedro Juan Parca, Edgardo Iriarte, Teofilo Deveraux, Eugenio Carlos De Hostos, Luis Emmanuelli, and Fasqual Lopez.

I have to cite the name of a great regiment, The 65th Infantry Regiment, nicknamed "The Borinqueneers" which is a word analogous to native Portoricans. Today the 65th is inactive, but it is ready to be present at anytime needed. The 65th proudly campaigned in the north of Africa and the European eastern fronts during the 2nd World War. I myself feel proud of being a memmber of the unit during the Korean Conflict and it is of right judgement to say that it was the unit that got the most Purple Hearts of all that represented the United States in the Peninsula's battlefield. I got my first Purple Heart while leading a squad in my first baptism of fire near the infamous Pork Chop Hill. I was also awarded a second Purple Heart when I returned to the Vietnam, battlefield for a second time, and distintively served with the 101st Airborne Division. My first tour was as an advisor,(covan) to a Vietnamese infantry battalion and I was presented with a

Silver Star for gallantry in action as I single handily faced an attacking force of two Vietcong battalions and later led a charge against enemy positions. I was also awarded the Gallantry Cross by the Vietnamese Command. Just like me, many Portoricans served and still serving today. I do have to cite my beloved father who distinctively served in the American Army from 1914 to 1917. A proud American that although never visited this mainland, he stood firmly and proud to be an American citizen. I have to stress that his military service along with many others paved the ways for the Portorican to become citizen of this great nation. My only two brothers were called to bear arms during the 2nd World War.

Recalling the numerical designation of some of the outstanding units that are today still ready to be call if needed are the 296th Infantry and the 245th Infantry regiments, but do not forget the first one organized under American Command, the magnificent 295th Infantry Regiment, and to be specific, this unit was organized on a very particular day, the 2nd of June of the year 1920. Exactly 12 years before my date of birth. A man who was a member of a delegation from Puerto Rico met the Great President John F. Kennedy at the White House. He was greeted by the President and addressed by him as "Mr. Cumbanchero".

He wrote poetry and music streesing the feelings of the militia as he was called to bear arms in defense of the country. The name of the man was Don Rafael Hernandez who in his feelings ~~were~~ and loving, having served as a soldier in the First World War just as my dear father, he wrote a beautiful composition called "Despedida" meaning Farewell in English. It tells about a soldier, a Borinqueneer who marching to the far away battle field, and gladly departing to fulfill his obligations, he resented having to leave his sweetheart and his good friends behind to include members of his family, but above all he regretted leaving his mother who was on her own with no one to take care of her.

Today the Portorican as part of the American Military Forces continue on call to render services proudly and with distinction. We can recall Korea, Vietnam, Grenada, Panama, The Dominican Republic, Honduras, Berlin Airlift, Somalia, Kuwait, and now Haiti among others. The Portorican militia, regardless of the branch of services is part of what we have accomplished and continue to do his duty defending the Democratic ideals. I will never forget the early fifties after returning from Korea and while on duty at Salinas Training Area in Puerto Rico, the firsts sixteen soldiers from the United States arrived to become part of the 296th Infantry Regiment. There were questions about who

could communicate with them at the training sessions. I stood up and volunteered my services although I did not speak perfect English. Just like me, others followed and like today side by side they do their duty regardless of the inconveniences.

I have to once more make references to units who are proudly ready to take part and respond ~~and~~ under the command of the Puerto Rico State Guard. I also have to mention my hometown called Guayanilla who's Honorable Mayor Ceferino Pacheco Giudicelli, also a Vietnam veteran, with enthusiastic spirit collected funds to erect a replica of The Ultimate Weapon representing not only the militia from my town, but every Portorican who served and still serving. The school from which I graduated bears the name of a fallen son who gave his life in the Second World War. The school name is Aristides Cales Quiros and I hope that will never be forgotten as others have been. I can recall a very touching and sentimental poem written by Professor Raul Crespo Nieves who dearly expressed his feelings about a street named after a young soldier who became a casualty in the battlefield in Vietnam and today generation don't care or know who he was. I fill proud of my 24 years of service as an American soldier and really it makes me feel better when I meet with some of my comrades or those who serve regardless of which branch of the Armed Forces are in. As a highly decorated veteran wearing proudly twenty nine decorations

hanging on my uniform my family feels honored. A Silver Star, 2 Purple Hearts and other commendation medals among my awards. I have to thank spiritually my beloved dear wife who passed away three years ago and for the years that she anxiously waited for my safe return while raising and taking care of our wonderful kids. I like to recall a saying repeated once in the ~~great~~ story Ben Hur, when after the commander of the naval float ship sunk by the enemy forces attack, Judas Ben Hur save his life and told him, "ow we're so we can keep the ship afloat.

Once more, I do thank all of you for listening and read my book, "The Advisor- Da Covan", you may like it and probably to many of you it may also bring some great memories.

...A1 GOD BLESS YOU.

Sincerely

Porfirio Torres-Gonzales
1SG U.S. Army Retired
Retired Teacher and Author

STATEMENT OF L.A. SANTILLANES, A HISPANIC VETERAN
BEFORE THE VETERANS AFFAIRS COMMITTEE
ON THE HISPANIC VETERAN AND HIS CONTRIBUTIONS TO THE NATION
September 14, 1994

MR. CHAIRMAN AND MEMBERS OF THE VETERANS AFFAIRS COMMITTEE:
CONCERNING THE HISPANIC VETERAN AND HIS CONTRIBUTION TO THE NATION.
MY NAME IS LOUIS ANTHONY SANTILLANES, I WAS BORN ON JUNE 21, 1932 IN
A SMALL COMMUNITY NORTH OF ALBUQUERQUE KNOWN AS ALAMEDA, N.M.
MY PARENTS WERE MOISES AND FAUSTINA SANTILLANES. MY FATHER WAS
POSTMASTER OF ALAMEDA FROM 1929 UNTIL 1945 AND THEN TRANSFERED TO THE
ALBUQUERQUE POST OFFICE AND MY MOTHER BECAME POST MASTER OF ALAMEDA
UNTIL HER RETIREMENT IN 1959.
I ATTENDED ELEMENTARY SCHOOL IN ALAMEDA AND GRADUATED FROM HIGH
SCHOOL IN ALBUQUERQUE IN 1951.
I JOINED THE US NAVY IN 1951 AND WAS A NAVY CORPSMAN WITH THE FLEET
MARINE FORCE IN KOREA. I WAS DISCHARGED FROM THE NAVY IN 1955 AT
PENSACOLA, FLORIDA. RETURNED TO NEW MEXICO AND ENROLLED AT THE
UNIVERSITY OF NEW MEXICO USING MY G.I. BILL.
I AM MARRIED TO THE FORMER BERTHA GARCIA OF BERNALILLO AND HAVE
FIVE CHILDREN HAVING LOST TWO: THE OLDEST IN A MOTORCYCLE
ACCIDENT IN 1968 AND THE OTHER MY YOUNGEST DAUGHTER MURDERED IN 1994.
I STARTED A CONSTRUCTION BUSINESS IN 1957 AND OPERATED IT FOR 2 YEARS
AND THEN CLOSED IT BECAUSE OF THE PROBLEMS WITH FINANCING. I THEN
ATTENDED THE CALIFORNIA COLLEGE OF MORTUARY SCIENCE IN LOS ANGELES.
AND, IN 1964 OPENED ALAMEDA MORTUARY AND HAVE OPERATED IT FOR THE
PAST 30 YEARS. IN 1987, I PURCHASED THE RIO RANCHO FUNERAL HOME
IN RIO RANCHO, N.M. AND NOW AM OWNER AND OPERATOR OF BOTH HOMES.
THE HISPANIC VETERAN IN THE STATE OF NEW MEXICO GOES BACK TO THE
FIFTEEN HUNDREDS. MY GREAT GRANDFATHER WAS ONE OF THE CONQUISTADORES

WHO CAME TO NEW MEXICO IN THE LATE FIFTEEN HUNDREDS.

THE CONTRIBUTIONS OF THE HISPANIC VETERAN BEGAN IN NEW MEXICO AND THE SOUTHWESTERN PART OF THE UNITED STATES; AT THAT TIME THE CONQUISTADORES ALTHOUGH CALLED CONQUERERS WERE ANYTHING BUT THAT. THEY BROUGHT THE CATTLE, HORSES AND SHEEP INTO THE AREA AND INSTEAD OF KILLING THE INDIANS THEY INTERMIXED WITH THEM AND INTERMARRIED AND TAUGHT THEM TO RAISE LIVESTOCK AND FARM, AND INTRODUCED THEM INTO THE CATHOLIC RELIGION IN NEW MEXICO. TO THIS DAY, THE NATIVE AMERICANS AND HISPANIC RELIGIOUS BELIEFS ARE INTERMIXED.

THEY ESTABLISHED THE FIRST SEAT OF GOVERNMENT IN THE NATION IN SANTA FE, NEW MEXICO AND IT IS THE LONGEST CONTINUOUS SEAT OF GOVERNMENT IN THE NATION.

HISPANICS IN NEW MEXICO HAVE BEEN INVOLVED IN AND BEEN A PART OF EVERY CONFLICT THE UNITED STATES GOVERNMENT HAS BEEN INVOLVED IN SINCE THEN: THERE WERE HISPANICS IN THE CIVIL WAR; THEY WERE INVOLVED WITH GENERAL PERSHING IN INVADING MEXICO WHEN PANCHO VILLA INVaded COLUMBUS, NEW MEXICO. THEY WERE PART OF TEDDY ROOSEVELT'S ROUGH RIDERS; THE HISPANICS WERE TRADING GOODS WITH SPAIN BEFORE THE PILGRIMS LANDED AT PLYMOUTH ROCK.

IN WORLD WAR I, THE MAJORITY OF THE SOLDIERS THAT WENT TO EUROPE FROM NEW MEXICO WERE HISPANIC. THEY RETURNED TO NEW MEXICO AND CONTINUED THEIR FARMS, RANCHES AND OTHER ENTERPRISES IN NEW MEXICO.

WHEN WORLD WAR II CAME ALONG-THE NATIONAL GUARD OF NEW MEXICO WAS ALREADY IN THE PHILLIPINES AND THE MAJORITY OF THE TROOPS WERE HISPANIC. THEY WERE THE ONES WHO DEFENDED CORRIGEDOR AND A MAJOR PART OF THEM WERE IN THE "BATAAN DEATH MARCH."

DURING WORLD WAR II THE PER CAPITA OF HISPANICS TO ANY OTHER

NATIONALITY JOINING THE SERVICE FROM NEW MEXICO WAS RATED NUMBER TWO IN THE NATION FOLLOWING THE STATE OF TEXAS, WHO WAS NUMBER ONE. WHEN THE KOREAN (WAR) POLICE ACTION CAME ALONG NEW MEXICO ROSE IN PER CAPITA TO THE NUMBER ONE STATE IN THE NATION OF HISPANICS IN THE MILITARY SERVICE OF OUR COUNTRY COMPARED TO THE OTHER NATIONALITIES IN THE STATE.

THE VIET-NAM CONFLICT (WAR) PRODUCED THE LARGEST PERCENTAGE OF HISPANIC VETERANS FROM THE STATE OF NEW MEXICO, AND THE LARGEST MAJORITY OF HISPANICS WHO WENT INTO THE MILITARY SERVICE.

THE NATIONAL GUARD AND ALL THE SERVICEMEN FROM NEW MEXICO INVOLVED IN GRANADA AND DESERT STORM AGAIN WERE FOR THE MAJOR PART, HISPANICS. ONE OF THE REASONS IS THAT THE MAJORITY OF HISPANICS CANNOT AFFORD TO ATTEND COLLEGE WITHOUT THE HELP OF THE G.I. BILL OR SCHOLARSHIP ASSISTANCE, SO THAT THEY HAD TO JOIN TO GET JOB OPPORTUNITIES.

THE HISPANIC VETERAN AND THE HISPANIC COMMUNITY COMPRISED THE MAJORITY IN THE STATE OF NEW MEXICO IN THE CENTRAL AND NORTHERN PART OF NEW MEXICO UNTIL THE LATE NINETEEN FIFTIES AND EARLY NINETEEN SIXTIES.

THEY WERE RESPONSIBLE FOR MOST OF THE PROGRESS MADE IN THE STATE UP TO THAT POINT. THE HISPANIC VETERANS MADE UP THE MAJORITY OF BOTH HOUSE AND SENATE AND THE MAJORITY OF THE ELECTED OFFICIALS OF THE STATE OF NEW MEXICO.

THE TURNING POINT IN NEW MEXICO FOR PROGRESS BOTH IN THE HISPANIC POPULATION AND THE STATE WAS THE INTRODUCTION OF THE HISPANICS TO ENGLISH LANGUAGE USAGE AND THE PASSAGE BY THE U.S. CONGRESS OF THE G.I. BILL OF RIGHTS. THIS ALLOWED THE HISPANIC VETERAN TO GET HIGHER EDUCATION AND WE IN NEW MEXICO GAINED MANY HISPANIC TEACHERS QUALIFIED TO INSTRUCT OUR CHILDREN, AND WE ALSO GAINED MANY OTHER

PROFESSIONALS.

THE HISPANIC VETERAN WAS ABLE TO BUY HOMES UNDER THE VETERAN LOAN GUARANTEE. THEY WERE ALSO ABLE TO GET BUSINESS LOANS AND IN THAT WAY WERE ABLE TO MAKE BIGGER AND MORE CONTRIBUTIONS TO THE DEVELOPMENT OF THE STATE OF NEW MEXICO.

THE STATE OF NEW MEXICO AND THE NATION OWES A GREAT DEAL TO THE HISPANIC VETERAN FOR THE NUMEROUS CONTRIBUTIONS THAT THE HISPANIC HAS MADE AND CONTINUES TO MAKE.

NOW, MORE THAN EVER THE HISPANIC VETERAN IS INVOLVED IN THE POLITICAL ARENA; THE LT. GOVERNOR OF THE STATE CASIMIRO (CASEY) LUNA IS A VERY SUCCESSFUL BUSINESS MAN AND POLITICIAN. HE CREDITS THE G.I. BILL FOR MUCH OF HIS SUCCESS.

THE FORMER CHAIRMAN OF THE VETERANS SERVICE COMMISSION FOR THE STATE OF NEW MEXICO IS A VIETNAM VETERAN WHO, ALSO CREDITS THE G.I. BILL FOR HIS LAW DEGREE AND SUCCESS.

THE LIST IS ENDLESS OF HISPANICS WHO HAVE CONTRIBUTED TO THE DEVELOPMENT AND PROGRESS OF NEW MEXICO. I FEEL THAT A LOT OF THE CREDIT MUST ALSO GO TO THE CONGRESS OF THE UNITED STATES FOR PASSING THE G.I. BILL AS IT WAS PRESENTED BY THE AMERICAN LEGION AND THAT THEY HAD THE FORESIGHT TO SEE THAT IF IT WAS GOOD FOR THE VETERAN IT WOULD ALSO BE GOOD FOR THE NATION. THE MONEY RETURNED TO THE TREASURY THROUGH TAXES FROM HIGHER INCOME DERIVED FROM BETTER JOBS THAT CAME AS A DIRECT RESULT OF HIGHER EDUCATION AND VOCATIONAL TRAINING. THE FARMERS, CATTLEMEN, SHOPKEEPERS AND ALL SEGMENTS OF THE POPULATION WERE AIDED BY THE EDUCATION AND LOAN GUARANTEES PROVIDED BY THIS MOMENTUS LEGISLATION.

WE MUST NEVER FORGET THIS CONTRIBUTION MADE BY THE HISPANICS AND ALL

THE OTHER VETERANS FOR THIS COUNTRY AND WE MUST CONTINUE TO AID THE NEW VETERAN BEING DISCHARGED NOW BY PROVIDING HIM OR HER THE SAME OPPORTUNITY TO RECEIVE HIGHER EDUCATION, VOCATIONAL TRAINING, JOB PROCUREMENT ASSISTANCE AND LOAN GUARANTEES.

**TESTIMONY
of**

**TINO ZAMORA
National Program Director**

**American Association of University Affiliated Programs
for Persons With Developmental Disabilities**

**Before the
Subcommittee on Oversight and Investigations
U.S. House of Representatives
Veterans Affairs Committee**

Topic:

**"Hispanic Veterans: Contributions to the Nation and Community; Receipt of
Federal Veterans Benefits
and Related Issues"**

September 28, 1994

Chairman Evans and members of the House Veterans Affairs Subcommittee, "Thank You" for inviting me to present testimony here today on the topics of - "Hispanic Veterans: Contributions to the Nation and Community; Receipt of Federal Veterans Benefits and Related Issues.

My name is Tino Zamora. I am a Vietnam Veteran and a Hispanic American. I come from a family with a long tradition of service to our country. My grandfather served in World War I, my step-father in Korea and several of my younger brothers also served in the military. One brother has decided to make the military his career.

My mother is a veterans' dependent under VA law and benefits, since my step-father was a totally disabled veteran and has since died of service connected injuries.

I mention my family because they have always been one of the most important influences in my life. I mention my family because I feel strongly that families are a key factor in addressing the needs of Hispanic populations, especially veteran populations. My testimony here today will, hopefully, elaborate my position and offer a challenge to those people interested in reaching and serving the Hispanic veterans community.

BACKGROUND

My background and experiences dealing with veterans is both personal and professional. I have worked with and for the veterans' community for well over 25 years. I am currently a National Project Director for the American Association of University Affiliated Programs for Persons with Developmental Disabilities here in Washington D.C. I specifically administer a training and technical assistance program targeted at Vietnam Veterans, their families, and their children with developmental disabilities. The program I administer is funded by the Agent Orange Class Assistance Program (AOCAP). I know that Chairman Evans is familiar with the AOCAP however other members of the committee may not - so I've attached a brief description of our purpose and mission.

In the past 25 years I have had the unique opportunity and pleasure of serving the Vietnam Veterans' community but it was not until recently that I realized that we were not truly meeting the needs of the veteran. It wasn't until I began working directly with the families of Vietnam Veterans that I understood the benefits and rewards of family-centered and family-focused approaches to helping and reaching the veteran. We had neglected a crucial part of a veterans' life - his family. In the past, our programs focused entirely on the veteran. For example, most traditional veteran programs target the veteran and his or her problems. The family is secondary to any solution. In my own case, whenever a veteran came in to our office with his family we would bring the veteran in for assistance while the family sat in the waiting room.

It never occurred to us to invite or include the family in the discussions. What I now realize is that, especially for Hispanic veterans, the family is central to any solution and can play a significant role in the process. Recent studies dealing with Hispanic populations and culture have shown that family involvement and identification are key characteristics of the Hispanic culture. It would seem obvious to anyone to target this group when working with this population. Mr. Chairman, I would venture to say that traditional approaches still do not see the family as key to addressing the needs of individual veterans.

THE CHALLENGE

The challenge is for traditional service providers, like the VA, to be more inclusive of the family in dealing with veterans. I know that some of my colleagues, here today, will testify as to the shortcomings of the VA in outreaching and serving Hispanic veterans. I would echo their concerns but would recommend to this committee that legislation be initiated immediately that defines families as part of the veteran community and eligible for certain services and programs along with the veteran himself or herself.

I'm sure the VA would debate the fact that they serve families today, but we all know VA law and it states they provide benefits and services to dependents. Dependents does not necessarily equate to family. Most family members are not qualified as dependents under VA law and would not be currently eligible for services. I would argue that without addressing the entire family in the context of the veteran is defeating the purpose of the help.

THE PLAN

Any effective strategy begins with a plan - a plan that thoroughly looks at the target audience. We need a survey or other research to define the problems of Hispanic veterans and their families as it relates to services and needs.

At the same time, VA should implement cultural awareness training regarding both general and specific facts about the Hispanic culture. The use of existing successful multicultural programs like those used by University Affiliated Programs (UAPs) should be investigated and implemented. I'm sure UAPs throughout our country would be interested in sharing their expertise in this area. Developing cultural competencies which acknowledge differences between people and cultures while at the same time developing effective programs for veterans and their families is paramount to any successful approach taken.

I would highly recommend to the VA to utilize existing programs like the AOCAP, at the community base level, to reach and address the veteran thru family-centered and family-focused programs. Why reinvent the wheel, when you already have it designed and operational? AOCAP projects could work in consort with VA programs to immediately address family and children issues. This would allow both

programs to leverage resources in a time when resource are limited and/or scarce.

CONCLUSION

Mr. Chairman, the members of the Hispanic Veterans Network, a coalition of programs and individuals working with Hispanic veteran populations is available to help develop a plan for addressing the needs and issues of Hispanic veterans. We "Thank" all the members of the committee for this opportunity to present our concerns and recommendations. I personally appreciate the opportunity to be heard. Once again, I thank you for inviting me to this hearing.

**AGENT ORANGE
CLASS ASSISTANCE
PROGRAM**

AGENT ORANGE CLASS ASSISTANCE PROGRAM

"The programs funded by the Agent Orange Class Assistance Program are filling a critical gap in services to Vietnam veterans and their families."

Congressman Lane Evans (D-IL)
Co-chair, Vietnam Era Veterans in Congress

AGENT ORANGE CLASS ASSISTANCE PROGRAM**BACKGROUND**

The Agent Orange Class Assistance Program (AOCAP) was established to distribute a portion of the fund created by the settlement of the class action lawsuit by Vietnam veterans and their families against chemical companies which supplied herbicides used in the U.S. war effort in Vietnam. The Assistance Program provides funding through grants to non-profit organizations for programs and services of benefit to Vietnam veterans and their families. Approximately \$42 million plus interest was made available for distribution under AOCP over its six to eight year program life.

The Assistance Program operates under the direction and supervision of United States District Court Judge Jack B. Weinstein who supervises the Agent Orange settlement. The broad mandate of the program is to make grants to support organizations and services which address the needs and concerns of Vietnam veterans and their families. The Court has directed that the Assistance Program give priority to the concerns which gave rise to the original lawsuit — providing services that are not currently available and bringing services to Vietnam veterans and their families who, for a variety of reasons, are not receiving needed assistance. For the purposes of the Assistance Program, the plaintiff class is treated as all persons who served in the Armed Forces in or near Vietnam between 1961 and 1972 and their spouses, children, and parents.

A court-appointed committee of nine unpaid advisors from around the country, all but one of whom are Vietnam veterans, aided the Assistance Program in its planning and determination of priorities in Program Year 1992-1993. They are:

Steven Champlin	Washington, DC
Ronald Gardner	New Orleans, Louisiana
Charles T. Hagel	Omaha, Nebraska
Mary Lou Keener*	Atlanta, Georgia
Gary E. May	Indianapolis, Indiana
Frank McCarthy	Orlando, Florida
Hon. Matthew Railey	Colorado Springs, Colorado
Dr. Oscar Salvatierra	San Francisco, California
Solomon B. Watson, IV	New York, New York

* Mary Lou Keener resigned effective in June of 1993 in order to assume the duties of General Counsel of the U.S. Department of Veterans Affairs.

AOCAP formally began on January 9, 1989, when the Court appointed an Executive Director, Mr. Dennis K. Rhoades, a Vietnam veteran with broad experience in veterans' policy and programs.

From its inception, the Assistance Program has made grant awards on a competitive basis. Three Requests for Proposal (RFP) have been issued since August of 1988 and have been widely distributed among veterans service and community based organizations, the disability community and other interested parties. RFPs are issued when a given pool of viable proposals is exhausted, or when programmatic objectives are changed or clarified. In all, more than three hundred proposals have been generated through the RFP process. The thrust of each successive RFP reflects the refinement process in program focus. The last RFP closed on June 30, 1991.

Preparations to begin awarding the first AOCAP grants were undertaken in January, 1989. AOCAP and the Court set out to identify major program goals with three key principles adopted during this period.

1. No programs duplicating government funded services would be considered. The Assistance Program also established a policy prohibiting replacement of public funds, no matter what circumstances were involved, with settlement funds.

2. Because of the public interest expressed since the early stages of the settlement in services to the developmentally disabled children of Vietnam veterans, AOCAP would give priority in funding to proposals which addressed the needs of this group.

3. Since the settlement affected class members throughout the nation, AOCAP would strive to obtain the widest possible geographic distribution of the projects it recommended to the Court for funding.

Although the \$42 million set aside by the Court for the Assistance Program represents a substantial investment in Vietnam veterans and their families, the size of the class and the diversity of needs present a formidable challenge in the equitable distribution of these non-renewable resources. While both the advisory board and the Court recognized the many worthy needs the constellation of proposals received by AOCAP was attempting to address, it was at the same time concerned that by distribution of funds into too many service areas the settlement would not achieve a positive lasting impact on the class.

During the program years 1990-1991 and 1991-1992, the program goals of the Assistance Program were developed and refined after numerous and thorough consultations with the AOCAP Advisory Board and the Court. In addition to serving as the overarching, broad goals of AOCAP, they have become the operational principles for the construction of each program funded by AOCAP. These goals focus in three major areas:

1. Services for Families *Provide case-management and counseling to Vietnam veterans in the context of their families which takes into account the veteran's war experience as a major contributing factor to family dysfunction.*

Public policy has long viewed the needs of returning veterans as specific to the individual. Members of the veteran's family, characterized as "dependents," are recognized as having needs, in general, only if the veteran is disabled or deceased. The Agent Orange plaintiff class includes the members of the veteran's family as equal partners, and AOCAP programs must address the needs of the family as a totality. In evaluating early grants, Assistance Program staff began to recognize the high degree of dysfunction among many of the families served. Grantees further reported that the incidence of dysfunction often appeared to be directly related to Post Traumatic Stress Disorder (PTSD). This evaluation paralleled the findings of the National Vietnam Veterans Readjustment Study which reported that 70% (of all Vietnam veterans with PTSD) have been divorced and 49% have high levels of marital or relationship problems. Currently, the U.S. Department of Veterans Affairs (VA) — through its Readjustment

AOCAP PROGRAM GOALS

The Billings Gazette WYOMING

Partners of veterans set up to educate, offer support

By PAT BLAIR
For The Gazette

SHERIDAN, Wyo. — It's in times like these that Susan Russell, partner, don't always understand their partners.

Agent Orange program gives family a future

By Colleen Lester
The Casper Star-Tribune

Twenty-year-old Terese Wright has multiple disabilities, she reads, writes and talks, but she mainly just sits.

Her parents — Bowmar, Luis and Fred Wright — believe Terese has been born with disabilities, but have her learning disability to Agent Orange during the Vietnam War.

Terese's life has not been easy. For years she has worked outside the home, doing odd jobs and repairing furniture, car seats and more.

But thanks to the Agent Orange Family Assistance Program, Terese's life is improving, not Terese and her family.

Funding for the program, which started in Wyoming recently, was received from another recently established Agent Orange program based in Los Angeles. A financial donation of \$100,000 was made available in 1990 by veterans who survived Agent Orange and their spouses for birth defects in their children.

In Idaho, the Wrights are among the families who have received help to handle costs associated with Agent Orange. They are seeking similar help from associations and foundations, as well as the state legislature, to expand the Agent Orange program.

So far, Pocatello, the university has helped a total of 10 families in Idaho. Wyoming and Nevada. See Program, C2

AGENT ORANGE FACTS

Agent Orange is a military code name for a weapon developed during the Vietnam War. The U.S. sprayed the defoliant over the jungles and forests of Vietnam and Laos to kill vegetation the enemy troops used as cover. The chemical consisted of equal amounts of herbicides and defoliants, 2,4-D and 3,5-T, which contains carcinogenic dioxin.

PROGRAM

Programs to assist Agent Orange survivors in

AGENT ORANGE CLASS ASSISTANCE PROGRAM

Counseling Program — provides very little family counseling. Through its network of grantees, the Assistance Program is filling a large gap in dealing with the effect of PTSD on families and in bringing a family centered approach to bear on the range of problems experienced by Vietnam veterans. The modern world of human services in the U.S. is moving rapidly toward an exclusively family-centered approach to the delivery of such services. It is hoped that through the work of AOCP, a similar family oriented approach will be brought closer to adoption within the realm of veterans' services.

2. Services for Children with Disabilities. *Build necessary links between the Vietnam veteran and Developmental Disability and other social services communities.*

Throughout the course of the Agent Orange litigation, plaintiff class members expressed concern for the health of their children. While it is not appropriate for the Assistance Program to judge the cause of any given disability, it is the responsibility of AOCP to attempt to address the needs of these children and their families. In doing so, the Assistance Program seeks to provide services to the children through the family, recognizing that a child's disability also adversely impacts those closest to him or her. In that regard, treating family dysfunction associated with a veteran's PTSD is particularly critical, both because there is evidence that family stress associated with PTSD is often aggravated by feelings of inadequacy due to the presence of a special needs child, and because a healthy family environment is necessary to advocate effectively on behalf of the child.

3. National Support Programs. *Establish a national support network, including a veterans law center, to provide technical assistance, training, and service linkages for the network of family services programs funded through AOCP grants.*

The Assistance Program's emphasis on services to families and disabled children involves many agencies with varying missions and specialties. Serving the needs of Vietnam veterans and their families requires, among other things, knowledge of veterans benefits, developmental disabilities, the effects of PTSD, SSI and Medicaid. For this reason AOCP supports a national network of programs which provide training and technical assistance to other AOCP grantees as well as other individual direct services providers. Organizations in this network include the National Veterans Legal Services Project, the American Association of University Affiliated Programs for Children with Developmental Disabilities, the National Information System for Vietnam Veterans and Their Families, the Bazelon Center for Mental Health Law, and the Access Group project of the United Cerebral Palsy Association.

Program for Veterans' Children with Disabilities
... nationwide, nonprofit
... information

Camp Pampankey
... for kids

NATIONAL RADIATION HELP LINE
... for veterans and their families

THE NATIONAL AMVET

CHILDREN OF VIETNAM VETERANS
... a non-profit organization dedicated to the welfare of children of Vietnam veterans. The organization is a member of the National Council of Vietnam War Veterans and their Families. The National Council of Vietnam War Veterans and their Families is a member of the National Organization of Vietnam War Veterans.

ANNIVERSARY COMMEMORATION
... The 10th anniversary of the Vietnam Veterans Memorial will be commemorated with a variety of year-long activities including educational seminars, concerts with entertainers, and a public education exhibition featuring the 23rd annual "Year of the Veteran" poster competition. The poster competition is open to all students in grades K-12. Entries will be submitted to the VA state veterans affairs office, county veterans service office, or the state veterans affairs department. The poster competition is the main program component of the

STATEMENT OF
JOSE LUIS MARTINEZ
BEFORE THE SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS
THE HONORABLE LANE EVANS, CHAIRMAN
WASHINGTON, D.C.
SEPTEMBER 28, 1994

Mr. Chairman, Congressman Gutierrez, Congressman Tejeda, other speakers, and guests. Good morning and thank you for the opportunity to appear before you and express my personal views and observations on outreach and service to the Hispanic Veteran.

My name is Jose Luis Martinez, I am a Readjustment Counseling Technician at the Veterans Resource Center in Chicago.

One aspect of my job is to conduct outreach to the Veteran community. During the past year I have concentrated my outreach efforts to the Latino Community in an effort to reach Latino Veterans and their families. I have had limited success. One of the factors is the size of the Latino community in Chicago. The problem still remains that awareness of VA benefits and programs is very low within the Latino community and greater efforts are required if we are to effectively serve this segment of society.

Sir, I am still one of three Latino counselors in the region (a thirteen state area). It is my view that Latino staff are still far too few in numbers to effectively outreach the many Latino Communities. Cities like Milwaukee, Minneapolis/St. Paul, Kansas City and St. Louis could particularly benefit from the hiring of Latino staff at Vet Centers. Counselors and Social Workers need to reach Latino veterans through shared cultural values. The Latino veterans must be approached with understanding of and sensitivity to his culture. The fact that a counselor or social worker can approach a veteran with a shared sense of culture and/or ethnic values can make the difference in whether or not you can gain the veterans trust and are therefore able to help him.

The obvious solution to outreach would be to hire more latinos, however that is not enough. A training program of cultural sensitivity should be implemented and maintained. This program must deal with issues affecting the Hispanic community, special needs of latino veterans both male and female, and issues and norms unique to latinos.

This leads to the area of opportunities within the Department of Veterans Affairs for Latinos. On this subject, I can only speak from personal experience.

I began my civil service career in 1974 with the Federal Aviation Administration as an Air Traffic Control Specialist, a position which I lost after participating in an illegal (though moral) job action in 1981. During the next seven years I made numerous applications with other Federal Agencies without success until 1988 when I was hired as a seasonal Tax Examining Clerk by the Internal Revenue Service. I resigned that position two seasons later due to a change in policy that I felt cheated elderly and poor taxpayers. I fought to reverse this policy to no avail.

Statement of Jose L. Martinez

I began my campaign for employment with the Department of Veterans Affairs in Jan. 1990 in St. Louis, Mo. I applied for all positions advertised for which I could qualify (in excess of 30 applications) without success until Aug. 1991 when I was appointed to a temporary position (less than 60 days) within the St. Louis Vet Center as an outreach specialist charged with initiating and maintaining an outreach program to returning Operation Desert Storm Vets. I remained in that position as a Volunteer until Dec. 1992 when I was notified that I had been selected for my present position.

Sir, I met the requirements on all positions for which I applied but, was interviewed only once and that only after an informal inquiry on my lack of success. On one occasion the published experience requirements were changed after the closing date of the announcement, effectively eliminating me from consideration. On another occasion I was offered a position as a food service worker (dish washer) after talking informally with an EEO representative. I had applied for a food service manager position and had not been interviewed or selected. I inquired about veterans preference and clarification on hiring practices. I was informed that the only positions within the Medical Center set aside for Veterans were 1. Food Service Worker (dish washer) and 2. Housekeeping Aid (Janitor). I can not prove that my ethnicity and/or my background were eliminating factors, but the fact remains that I was not able to secure a position within the St. Louis Medical Center.

I applied for employment in other geographical areas (Greensboro, NC; Kansas City, Mo) and other agencies (Social Security Administration, U.S. Customs, etc.) on several occasions I found out that the person hired was non-veteran and non-minority. On the position in Greensboro The selecting official stated during a phone conversation that the hospitals personnel department had dictated to him hiring the non-veteran since she was already within the hospital system though her qualifications were no greater than mine.

There appears to be an ultra-conservative faction within the personnel offices in the VA Medical Centers that handicaps veterans applying for employment, and being a Vietnam Veteran is the equivalence of having an albatross around your neck.

A new direction is needed in assuring veterans preference within the VA and in designating more positions for veteran applications only. Utilization of the Veterans Readjustment Act provisions must become a priority. Greater attention and closer supervision and monitoring of personnel officers is needed to insure veteran preference programs and directives are being followed.

If and when the obstacles to employment are reduced or eliminated and a greater number of Latinos can be hired to service the Hispanic Community and greater number of Latino vets begin to utilize the VA facilities. This can reduce the negative incidents experienced when seeking medical services in the VA Hospitals.

Statement of Jose L. Martinez

Examples of these negative incidents include:

Case 1. [REDACTED] a Puerto Rican Veteran who sought help at a local VA Medical Center after he had been denied services and medication (methadone) at a community mental health program because of his inability to pay. Mr. [REDACTED] is a homeless veteran. He had recently returned from Puerto Rico thinking he had greater opportunity in Chicago. Mr. [REDACTED] is a recovering heroin addict with an extensive medical history including open heart surgery and a brain aneurysm. Mr. [REDACTED] spent numerous hours in the emergency room feeling neglected and ignored. He was released without help or medication (methadone or heart medication). He spent several days on the street then participated in the standdown where he was able to receive assistance and services (bus tokens for transportation, clothing, shoes, etc.). During the standdown Mr. [REDACTED] was going through withdrawal from methadone and experienced a severe seizure which required hospitalization. Mr. [REDACTED] was finally able to get into a methadone program sponsored by a community mental health clinic in the Latino community. Mr. [REDACTED] is currently an inpatient at Hines VA Medical Center suffering from severe seizures which Doctors are investigating and believe are related to the aneurysm.

Case 2. [REDACTED] a woman veteran with a case history of cardiovascular and glandular problems. She sought help at the same Medical Center because of severe chest pains. She had recently relocated from San Antonio, Texas where she had received treatment at the VA Medical Center. Ms [REDACTED] is medically retired having worked as a Social Worker for over 20 years with Texas Department of Human Services. She is on a very limited income and the VA System is the only viable option for health care. On her initial visit she was kept waiting in excess of six hours and was still in the lobby when the clinic was closed for the day and the Doctors left. She was interviewed by a nurse at the desk and told she was not sick enough and was given a bottle of maalox for her symptoms. She later sought service at Loyola Medical Center in Maywood where her examining physician recommended that she be admitted to Hines VA Medical Center where he also practiced because of her inability to pay at Loyola. She was admitted at Hines and underwent a series of tests which verified a mild heart attack. She remained in the hospital over two weeks and was scheduled for angioplasty procedures which were performed at a later date.

These cases are not unique, but an indicators of what is happening to Latinos and other minority veterans within the system.

As Latinos, our English is accented, we sound different, and we encounter the problem that others listen to our accent and not to what we are saying.

Another issue is that of status. Latinos as a major ethnic minority are second only to the American Indian in historical priority, having been in parts of this nation even before the ethnic majority arrived on these shores. At the same time with recent arrivals from Cuba, Mexico, and other Latin American Countries, we are the most recent immigrant group. This puts us in a curious paradox, we are such an old group that we have been forgotten much like the American Indian and so new we are just being discovered.

Statement of Jose L. Martinez

A focus group need to be formed to identify needs within the community and recommend a plan of action to alleviate these needs.

Outreach needs to be coordinated to insure coverage of the whole community without duplicating efforts. Outreach efforts need to be expanded to community based and social organizations getting them involved in recruiting and/or recommending candidates for services or employment.

A recruitment program needs to be implemented to target Latino students in colleges and Universities utilizing the outstanding student program. Professors, counselors and school administrators need to be recruited to identify qualifying students.

A program of involvement in public and private elementary and high schools within the Latino community should be implemented to identify children of veterans and have presentation on services, programs, and careers tailored to them.

STATEMENT
OF
ANDREW RODRIGUEZ
LABOR SERVICES REPRESENTATIVE
(DISABLED VETERAN OUTREACH) PROGRAM
NEW YORK STATE DEPARTMENT OF LABOR

Good morning Mr. Chairman. My name is Andrew Rodriguez. I work for the New York State Department of Labor as a Labor Services Representative (Disabled Veteran Outreach). I am what is known as a Disabled Veterans Outreach Program Specialist or DVOP. From 1968 to 1969 I served as a weapons specialist in a marine "recon" unit in the Republic of Vietnam. I was wounded in action and received the Purple Heart.

I wish to extend our thanks and congratulations to you and your Committee on Veterans' Affairs for holding this hearing to focus attention on "Hispanic Veterans: Veterans' Readjustment Benefits and Related Issues."

The Disabled Veterans Outreach Program is described in Section 4102(A)(b)95)(A)(I) of Title 38. Funding is intended to be made available to each state sufficient to support the appointment of one DVOP for each 6,900 veterans residing in such states, who are recently separated, Vietnam era or disabled veterans.

Preference in appointment is given to qualified, disabled veterans of the Vietnam Era. The role of a DVOP role is to provide the maximum amount of service with emphasis on job placement, and to ensure that the needs of other economically or educationally disadvantaged veterans are addressed. DVOPs in each state are stationed in local employment service offices with at least 25% being outstationed at Veteran Outreach Centers of the U.S. Department of Veterans' Affairs and other appropriate sites. Each DVOP provides service to eligible

veterans, develops job and job training opportunities through contacts made with employers (especially small and medium sector employers) and perform other functions within the parameters allowed by law.

I have served for several years as a Disabled Veterans Outreach Program Specialist based out of the New York State Department of Labor, West Fifty-fourth St. Community Service Center in Manhattan. This facility is one of the largest in the nation and serves as many individuals as some of the smaller states. Many of the veterans I serve at this location are of Hispanic-American or African-American heritage. I provide them with a wide range of services out of our VET TAC Unit. VET TAC is the Veterans Testing and Advisement Center. It was established in 1990 to provide counseling and vocational guidance to veterans. In addition, we provide testing, referral, and placement services and are considered a New York City regionwide resource for the more specialized services.

In 1988, Governor Mario M. Cuomo established the "Veterans Bill of Rights for Employment Services" at the New York State Department of Labor. An essential element of this initiative is the "Veterans Employment Hotline" which was set up to provide veterans from all parts of New York State with information on employment, training that will lead to employment, where and how to access information and assistance in obtaining federal and state benefits. In short, we provide a myriad of services all designed to place veterans in meaningful jobs. While veterans anywhere in the United States have certain rights to priority service pursuant to provisions of Title 38, Chapters 41, 42, 43 of the United States Code, the average veteran is often unaware of what rights he or she may have under the law. The "New York State Veterans Bill of Rights" is based on the premise that every veteran should be informed of his or her rights in a clear, concise manner and be provided with a simple but effective means of redress if those rights have been abridged. Those five rights are:

1. To ensure that veterans are treated with courtesy and respect at all NYSDOL facilities.

2. To give priority in referral to jobs to qualified veterans and eligible persons.
3. To give priority in referral to training to qualified veterans and eligible persons.
4. To give preferential treatment to special disabled veterans in the provision of all needed local office services.
5. To provide information and effective referral assistance to veterans and eligible persons regarding needed benefits and services that may be obtained through other agencies.

These are posted in several locations in each New York State Department of Labor facility, including each waiting area. Each man and woman who comes to us for service is asked, "Did you ever serve on active duty in the United States military?" If the answer is yes, that person is provided with a wallet card which lists their rights as well as other information and lists the toll-free "Veterans Employment Hotline" number. I have attached a copy of this card as Appendix I to this statement and provided some originals to your staff.

At least sixteen other states have followed New York's lead and promulgated a "Veterans Bill of Rights for Employment Services" in one form or another, based on Governor Cuomo's model. Some states, such as Michigan and Ohio, have done this by enacting state laws. Other states such as Mississippi, New Jersey, Connecticut, California, West Virginia, and Florida, have done so by means of administrative action or Executive Order by their Governor. While New York accomplished implementation of the original "Veterans Bill of Rights for Employment Services" model by means of administrative actions, those actions are now affirmed and expanded with enactment of Chapter 553 of the Laws of New York State on July 26, 1994, which extend preference to veterans in all federally-funded employment, training, and remediation programs operated by or through New York State government entities.

A copy of this legislation and the Approval Message of Governor Mario M. Cuomo is attached as Appendix II.

The purpose of this hearing is to determine the impact that this activity has on Hispanic-American veterans and their need for services to assist them in successfully readjusting to American society. In response, we believe that the ability to obtain and sustain meaningful employment at a decent living wage is at the crux of the readjustment process.

According to the United States Department of Veterans' Affairs, Analysis and Statistics Service, there are over 75,000 veterans of Hispanic-American origin in New York State. That number represents the third largest Hispanic-American veteran population in the nation (behind California and Texas) and the largest of Puerto Rican heritage.

The median income for Hispanic-American veterans equals only about 80% of their white counterparts, according to the same USDVA study. With the exception of veterans over age 54 and under age 25, Hispanic veterans have much lower labor market participation rate than white veterans. The greatest disparity is among Hispanic-American veterans of the Vietnam era. This disparity is even greater among this group in median income.

The disparity in objective measurement of economic well-being of Hispanic-American veterans versus their white counterparts is one that is long standing in nature, and has not lessened appreciably in the last twenty years.

The connection between readjustment problems due to military service and employment as a reflection of successful readjustment can best be seen by comparing statistics from the National Vietnam Veterans Readjustment Study results issued in July of 1988 with the unemployment rates of Vietnam Era veterans issued at the same time by the Bureau of Labor Statistics, United States Department of Labor (NEWS, U.S. Bureau of Labor Statistics, USDL 88-489). In Appendix III,

please find graphs that compare Post Traumatic Stress Disorder (PTSD) prevalence rates of Vietnam combat theatre veterans by ethnic group with the unemployment rate by ethnic group from a survey conducted at the same time. Most alarming is the prevalence rate of PTSD among Hispanic Vietnam theatre veterans, which, at 27%, exceeds that of Black Vietnam theatre veterans (19%) and white Vietnam theatre veterans (14%).

You will note that the pattern is the same for both studies, suggesting a correlation between significant readjustment problems and ability to sustain meaningful employment. This is particularly significant given that an increasing proportion of United States military forces are Hispanic-American and other minorities. Large numbers of these men and women serve in the combat arena and are most likely to be exposed to situations that can lead to significant post-service readjustment problems, including Post Traumatic Stress Disorder.

We must focus on the steps Congress and others can take to address and hopefully reverse this disparity in the ability of Hispanic-American veterans to secure vitally needed services that will enable them to obtain and sustain meaningful employment, strengthening the fabric of our economic life and our communities. While we are not prepared to offer prescriptive solutions that would "solve" these problems, we would like to offer recommendations or fruitful areas of inquiry and/or action.

First, it may prove to be of particular benefit to Hispanic-American veterans if a great deal more attention and emphasis is directed toward ensuring that the elements of the United States Department of Veterans' Affairs, specifically the Readjustment Counseling Service (Vet Centers) and Vocational Rehabilitation, were truly functioning in a collaborative and active way with the state employment security agencies on the needs of the veteran customer at the operational level. In particular, greater cooperation with the Disabled Veterans Outreach Program is clearly indicated.

Second, full funding of the Disabled Veterans Outreach Program and Local Veterans Employment Representative Programs to the full number of Full-Time Employee Equivalents (FTEE) mandated in Chapter 41, Title 38, United States Code would be of significant help in providing enhanced services at the local delivery level. These programs have been critically underfunded for the past three years. We have also heard that there is substantial underfunding proposed for Fiscal year 1995. We have already seen dramatically reduced resources from what the state employment security agencies received from the Federal Unemployment Trust Account (FUTA) as recently as six years ago to operate the basic labor exchange and unemployment compensation system.

Since 1988, New York State has lost more than half of the number of FTEE positions funded under Wagner-Peyser to operate the basic public labor exchange. While reduction in veterans staff has not been as dramatic, it has diminished the overall resources available, creating a negative impact on veterans as well as non-veterans. Additional underfunding in Fiscal Year 1995 can only exacerbate an already critical situation.

Third, while we have made significant progress in securing gains in New York in both the quantity and quality of services available to veterans under Title IIA of the Job Training Partnership Act (JTPA) and under Title III of the JTPA (also known as the Economically Dislocated Worker Adjustment Assistance Act or EDWAA), these gains have only been made possible as a result of concentrated support from Governor Cuomo via the New York State Veterans Bill of Rights for Employment Services. There is no requirement in the Job Training Partnership Act or other significant federal programs which specifies priority service for any veterans, much less minority veterans. In the "Governor's Coordination and Special Services Plan," submitted to the Secretary of Labor in order to secure JTPA funds for New York, Governor Cuomo has designated veterans, particularly Vietnam theatre and other combat theatre veterans, minority veterans, disabled veterans, and recently separated veterans as a "special emphasis priority group" for special

attention at the service delivery level. Action by Congress would make this possible in other states.

Fourth, since many veterans are faced with pressing basic survival needs, they find it difficult to enter into classroom training. The new JTPA rules make it much more difficult for on-the-job training (OJT) opportunities to be structured under EDWAA and Title IIA of the Job Training Partnership Act. The Service Members Occupational Conversion Training Act (SMOCTA) is a very exciting priority program for recently separated veterans. We believe that it should be extended, if indeed not made permanent as a new entitlement under the Montgomery GI Bill. It is worth noting that 49% of those who used the WWII, Korea, and Vietnam GI Bills, used it for OJT, vocational training, or apprenticeship. Such an OJT program would be useful in particular for Hispanic-American veterans in light of the income disparity previously noted, and the need to earn an income while training. Our fellow veterans in the Latino Community need to be able to survive while they acquire skills which will lead toward career-oriented employment. Often the only way to do this is with a structured on the job training program.

Fifth, since language remains a barrier in some segments of our population, we would like to see Spanish-language brochures and posters produced by federal agencies that serve veterans. In New York State all of our outreach materials for veterans are printed in Spanish. Although as veterans of the United States military we are proficient in the English language, we are also the least likely to seek services at governmental agencies. These Spanish-language materials could effectively increase awareness of veterans programs and our participation in them.

Mr. Chairman, thank you for the opportunity to present these observations and suggestions to you and your committee today. On behalf of the Honorable John F. Hudacs, Commissioner of Labor for the State of New York, myself, and my colleagues, thank you for your leadership in holding these hearings.

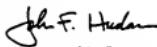
Veterans Bill of Rights

The NY State Department of Labor's commitment to veterans is:

1. To ensure that veterans are treated with courtesy and respect at all NY State Department of Labor facilities.
2. To give priority in referral to jobs to qualified veterans and eligible persons.
3. To give priority in referral to training to qualified veterans and eligible persons.
4. To give preferential treatment to special disabled veterans in the provision of all needed local office services.
5. To provide information and effective referral assistance to veterans and eligible persons regarding needed benefits and services that may be obtained through other agencies.



Mario M. Cuomo
Governor



John F. Hudacs
Commissioner of Labor

**Services provided by the
Community Service Center
New York State Department of Labor**

Job referral and placement

Job development

Vocational exploration

Testing

Certification for Targeted Tax Credits

Information on training opportunities

Referral to other supportive service agencies

Assistance in referral to unemployment insurance

Assistance in filing complaints

If you believe the Department's commitment to veterans has not been met, request to see the local Community Service Center veterans representative or the local office supervisor.

If you require further assistance, or desire additional information, please call.

1-800-342-3358

VETS-110-92

Bring appropriate

Bring proof of eligibility to work

Bring your dates of military service

Bring a work history fact sheet or resume

Bring your Social Security card

Job Interview Tips



Helping NY work
VETS
Bill of RIGHTS

**Declaración De Derechos
De Los Veteranos**

**El compromiso del Departamento de Trabajo
del estado de Nueva York con los veteranos es:**

- 1) Continuar brindando servicios a los Veteranos en todas las oficinas del Departamento de Trabajo del Estado de Nueva York, con el mismo esmero y la misma cortesía, con que siempre lo hemos hecho.
- 2) Dar prioridad a los Veteranos calificados y personas elegibles al referirlos a empleos.
- 3) Dar prioridad a los Veteranos capacitados y personas elegibles al referirlos a adiestramientos.
- 4) Dar trato preferencial a los Veteranos que tengan incapacidades, para que sean provistos con todos los servicios necesarios de las oficinas locales.
- 5) Proveer información y ayuda efectiva de referimiento a los Veteranos y personas elegibles cuando necesiten beneficios y servicios que pueden ser obtenidos a través de otras agencias.


Mario M. Cuomo
Gobernador


John F. Hudacs
Comisionado de Trabajo

**Servicios que Ofrece la División
de Empleo del Departamento de Trabajo
del Estado de Nueva York**

Referencias de empleo y colocación
Desarrollo de empleos
Exploración vocacional
Exámenes

Certificación para ciertos créditos de impuestos
Información sobre oportunidades de adiestramiento
Referencias a otras agencias de servicios
Ayuda con referencias para el seguro por desempleo

Si usted cree que el compromiso del departamento De Trabajo con los veteranos no se ha cumplido, pida una cita para ver al representante de veteranos de la oficina local del Servicio de Empleo (Job Service) o al supervisor de la oficina local.

Si necesita más ayuda o desea información adicional, llame al

1-800-848-4949

VET 154-921
Vístase Apropiadamente

Lleve la Prueba de Elegibilidad para Trabajar

Lleve las Fechas de su Servicio Militar

Lleve su Historial de Trabajo O Resumé

Lleve su Tarjeta de Seguro Social

Empleo

Sugerencias para la Entrevista de



STATE OF NEW YORK--
EXECUTIVE CHAMBER
MARIO M. CUOMO, GOVERNOR

Appendix II

Press Office
518-474-8418
212-417-2126

FOR RELEASE:
IMMEDIATE, FRIDAY
JULY 29, 1994

STATE OF NEW YORK
EXECUTIVE CHAMBER
ALBANY 12224

July 26, 1994

MEMORANDUM filed with Assembly Bill Number 3671-D, entitled:

"AN ACT enacting the New York State Veterans
Bill of Rights for Employment Services,
in relation to establishing a priority
system for veterans in employment and
training programs administered by the
state"
#32
(Chapter 553)

A P P R O V E D

In 1988, I launched the Veterans Bill of Rights for Employment Services. Through that program, I directed the State Department of Labor to work with the Division of Veterans' Affairs and the veterans community to maximize the opportunities for veterans seeking meaningful work. Most significantly, I designated veterans as a target group to receive priority status in referrals to both jobs and training programs, and I directed that preferential treatment be given to special disabled veterans in the provision of services.

Based on my longstanding commitment to the veterans community, and to insuring that we repay our debt to these brave men and women, I commend the Legislature on the passage of this bill, the New York State Veterans Bill of Rights for Employment and Training Services.

The bill provides that veterans who meet all eligibility requirements for federally-funded employment and training programs be given preference in referral to those programs over non-veterans. In making such referrals, the bill sets up a system of priorities as amongst veterans. The bill further provides that all state agencies administering such programs appoint a veterans coordinator to insure that all services are provided in accordance with this Bill of Rights.

The intent of this bill is clear, and is in full keeping with the policies of my administration to give preferential status to veterans within the context of the full federal funding we receive to administer employment and training programs. Although there are certain technical problems in the bill, the Legislature has agreed to remedy these through a chapter amendment.

The bill is approved.

Appendix II

STATE OF NEW YORK

3671--D

1993-1994 Regular Sessions

IN ASSEMBLY

February 16, 1993

Introduced by M. of A. MCENENY, PARMENT, MORELLE, LAFAYETTE, TOKASZ, TONKO, TOCCI, DESTITO, COLMAN, HOCHBERG, PRETLOW -- Multi-Sponsored by -- M. of A. ABBATE, BECKER, BIANCHI, BRAGMAN, BRENNAN, CAHILL, CANESTRARI, CLARK, CONNELLY, GENOVESI, GRABER, HARENBERG, HICKEY, HOFFMAN, KAUFMAN, LEIBELL, LUSTER, MAGEE, MATUSOW, MEEKS, NICOLETTI, NOLAN, PHEFFER, PORDUM, RAMIREZ, ROBACH, SEMINERIO, WEISENBERG, WRIGHT -- read once and referred to the Committee on Veterans' Affairs -- reported and referred to the Committee on Rules -- Rules Committee discharged, bill amended, ordered reprinted as amended and recommitted to the Committee on Rules -- recommitted to the Committee on Veterans' Affairs in accordance with Assembly Rule 3, sec. 2 -- committee discharged, bill amended, ordered reprinted as amended and recommitted to said committee -- reported and referred to the Committee on Rules -- committee discharged, bill amended, ordered reprinted as amended and recommitted to said committee -- again reported from said committee with amendments, ordered reprinted as amended, and recommitted to said committee

AN ACT enacting the New York State Veterans Bill of Rights for Employment Services, in relation to establishing a priority system for veterans in employment and training programs administered by the state

The People of the State of New York, represented in Senate and Assembly, do enact as follows:

- 1 Section 1. The legislature hereby finds and declares that the men and
2 women serving in our Nation's Armed Forces are of the highest caliber
3 and intelligence, and are dedicated and disciplined.
- 4 The legislature finds that at least sixty-one thousand separating
5 veterans will be returning to New York state by 1995 due to the downsizing
6 of the military and base closings.
- 7 The legislature further finds and declares these men and women will be
8 entering the civilian workforce during a time of economic uncertainty.

EXPLANATION--Matter in italics (underscored) is new; matter in brackets
[] is old law to be omitted.

LBD04768-13-4

A. 3671--D

2

1 Many of these returning servicemen and women have specialized skills
2 which may not be transferable to the civilian workforce.

3 Further, the legislature declares a veteran who is both eligible and
4 qualified for any federally-funded employment and training programs in-
5 cluding but not limited to the Job Training Partnership Act (P.L. 97-
6 300) as amended by the Job Training Reform Amendments of 1992 and any
7 successor acts, shall be given preference for referral over a non-
8 veteran eligible for these programs.

9 § 2. Short title. This act shall be known as the "New York State
10 Veterans Bill of Rights for Employment and Training Services".

11 § 3. Definitions. As used in this act:

12 1. "Special disabled veteran" means a veteran who is entitled to, or
13 who but for the receipt of military retirement pay would be entitled to,
14 compensation under any law administered by the United States department
15 of veterans' affairs for a disability rated thirty percent or more or a
16 person who was discharged or released from active duty because of a
17 service-connected disability.

18 2. "Vietnam-era veteran" means an eligible veteran, any part of whose
19 military, naval, or air service was during the Vietnam era of December
20 22, 1961 through May 5, 1975.

21 3. "Disabled veteran" means a veteran who is entitled to, or who but
22 for the receipt of military retirement pay would be entitled to compen-
23 sation, under any law administered by the United States department of
24 veterans' affairs and who is not a special disabled veteran.

25 4. "Combat theater veteran" means any member of the armed forces of
26 the United States who served in a campaign or expedition for which a
27 campaign ribbon or combat badge is authorized and who was discharged or
28 released from such duty with other than a dishonorable discharge.

29 5. "Recently separated veteran" means any person who served more than
30 one hundred eighty continuous days or on active duty within the previous
31 forty-eight months with other than a dishonorable discharge.

32 6. "Employment and training programs" means any federally-funded edu-
33 cation, training, remediation or rehabilitation program administered by
34 a state agency that is directed at improving the employability or skills
35 of enrolled participants including but not limited to the Job Training
36 Partnership Act (P.L. 97-300) as amended by the Job Training Reform
37 Amendments of 1992 and any successor acts, and all employment services
38 offered through the community services division of the department of
39 labor.

40 § 4. Veterans priority system. Veterans who meet eligibility require-
41 ments for any employment and training program administered by any state
42 agency shall be given preference in referral to those programs over non-
43 veterans. Veterans shall be referred according to the order of priority
44 set forth in section five of this act.

45 § 5. Order of priority. Each state agency shall refer veterans to em-
46 ployment and training programs according to the following order of
47 priority:

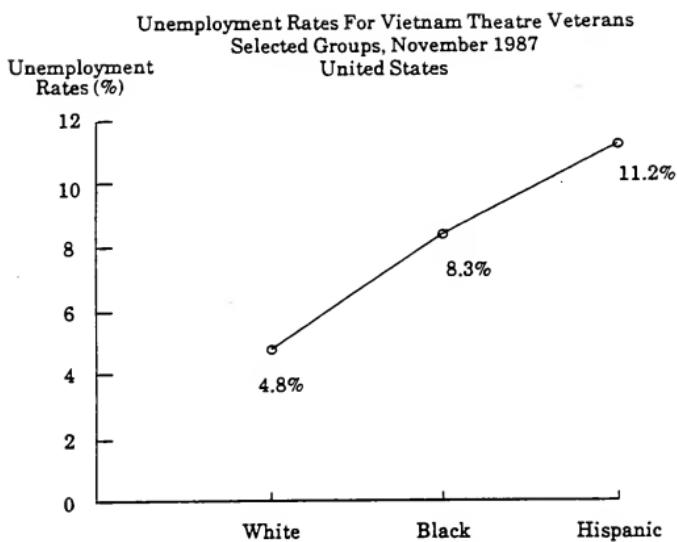
48 1. Special disabled veterans;
49 2. Vietnam era veterans;
50 3. Disabled veterans;
51 4. Combat theater veterans;
52 5. Recently separated veterans; and
53 6. Other veterans.

54 § 6. Reporting. Each state agency administering employment and train-
55 ing programs shall submit an annual written report to the governor, the
56 speaker of the assembly and the temporary president of the senate on the

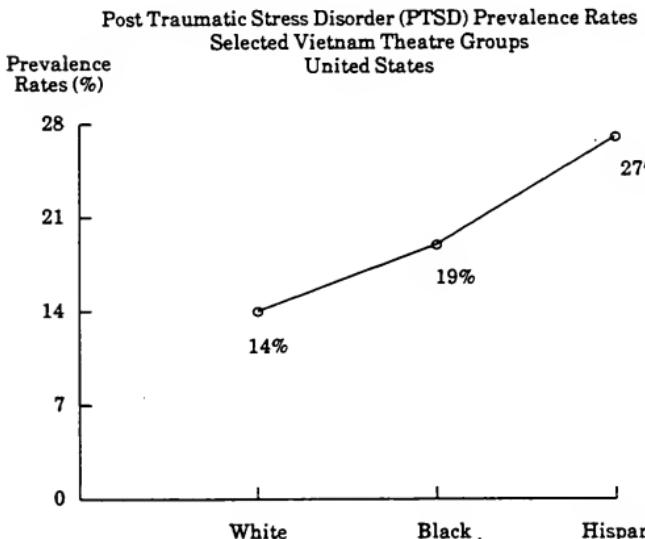
A. 3671--D

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1 services provided to veterans. Each annual report shall include but not
2 be limited to:
3 1. the numbers served for each priority group defined in section five
4 of this act; and
5 2. actions taken to ensure compliance with requirements under this
6 act.
7 5 7. Administration. 1. Each state agency shall designate an adminis-
8 trator or coordinator of veterans services who shall ensure that
9 requirements under this act are carried out and that active communica-
10 tion, coordination, and cooperative efforts are maintained with other
11 state agencies.
12 2. Such veterans services administrator or coordinator positions shall
13 be funded from existing appropriations in such agencies.
14 3. A listing of all veterans services administrators or coordinators
15 shall be maintained by the division of veterans' affairs and updated
16 annually.
17 5 8. Agency duties and responsibilities. All state agencies adminis-
18 tering employment and training programs shall:
19 1. ensure that veterans are treated with courtesy and respect at all
20 state governmental facilities;
21 2. provide information and assistance to veterans regarding benefits
22 and services that may be obtained through other agencies, including but
23 not limited to the division of veterans' affairs;
24 3. inform each veteran of his or her rights; and
25 4. provide an ongoing in-service training program for agency staff on
26 how to identify and address the special needs for veterans.
27 5 9. This act shall take effect immediately.



Source: NEWS, U.S. Bureau of Labor Statistics, USDL 88-489



Source: National Vietnam Veterans Readjustment Study, July 1988



PUERTO RICAN VETERAN'S ASSOCIATION OF MASSACHUSETTS, INC.

Springfield Bilingual Veteran's Outreach Center

P.O. BOX 70186, 186 MILL STREET
SPRINGFIELD, MA 01107

Executive Director
Gumeraldo Gomez

(413) 731-0194

FAX # (413) 736-2008

President
Sergio Kentish

September 23, 1994

Congress of the United States
House of Representatives
Committee on Veterans' Affairs
Washington, DC. 20515

Mr. Chairman, members of the Committee on Veterans Affairs, The Puerto Rican Veteran's Association of Massachusetts, Incorporated, welcomes the opportunity to share our experiences within the Hispanic Veteran's Community on HOMELESSNESS.

As one of nine Veterans Outreach Centers in the Commonwealth of Massachusetts, we are the only Hispanic Veterans Outreach Center that operates, to provide services to those who have served, and answer the call of duty to this grateful nation in the time of need.

About 90% of all the veterans that we serve, are of Puerto Rican Ethnic background. We are serving Veterans that have served as early as World War I, and through The Persian Gulf War.

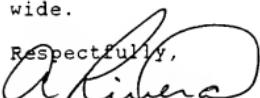
This association has work many cases in the area of providing assistance to Hispanic Veterans. The picture that is provided on the actual cases on Hispanic Homeless Veterans is really unclear, this is due to our culture. We have seen many families that are legally homeless, but due to our cultural background, our families will not tolerate our own from being place in the streets. Our families on the average will be placing themselves in harms way by providing the homeless with a roof over there heads specially when that family is receiving assistance from any type of program.

In general, the homeless population in this nation is unsatisfactory. Granted, we do have veterans that do not have this luxury. We all know, that the majority of veterans within the homeless population are Afro-American and Hispanics, around 40% nation wide. This is created by drugs and alcohol. Another point to mention is that the majority of these homeless veterans received a less favorable type of discharge from the Armed Forces.

One special group of veterans, is the Vietnam War Veteran where these veterans provided valuable service in combat operations in South East Asia. Accordingly, many articles have been published, that this group of veterans make up the greatest population within the homeless community. One of the reason that these veterans are homeless, is that when these veterans return from Vietnam they received "BAD PAPER" due to Post Traumatic Stress Disorder (PTSD), drug and alcohol dependency.

The Armed Forces never considered the sacrifice that these veterans made for this country. Many Vietnam War Veterans are highly decorated war veterans that were willing to give up their lives. Congresswoman Ms. Maxine Waters from California has proposed that consideration be given to this group of veterans to upgrade their discharge characterization and give them the benefits they rightfully deserve. We believe this will have an impact in reducing the percentage of homeless veterans.

There is so much more that could be done, however, this is only a small stepping stone to curtail the homeless population within this grateful nation of ours. In closing, I will state, that there is a tremendous need for a culturally sensitive outreach program to the Hispanic veteran community. The Department of Veterans Affairs must also increase their bilingual staff to provide assistance to those Hispanic veterans that have a language deficiency that exist in this nation. Many Puerto Rican veterans relocating to the United States have , and will continue to have this problem for many years to come, this is why it is imperative that a coalition be set-up to help this veterans. This program should be funded at the federal level with offices nation wide.

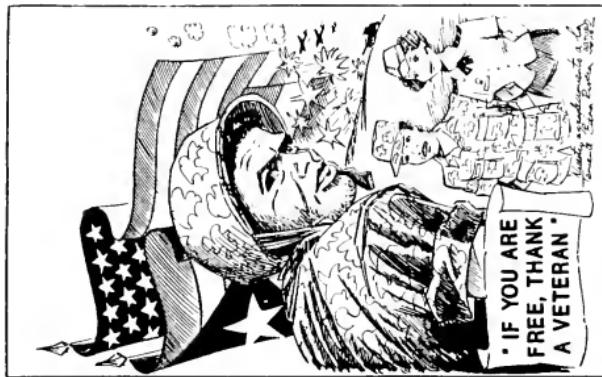


Respectfully,

AGAPITO RIVERA
VETERANS OUTREACH SPECIALIST
1STSGT USMC/RETired
SEMPER FIDELIS

**PUERTO RICAN VETERANS'
ASSOCIATION OF MASS., INC.**

**SPRINGFIELD BILINGUAL
VETERANS' OUTREACH CENTER**



• IF YOU ARE
FREE, THANK
A VETERAN •

- La Asociación tiene una junta de directores quien supervisa el centro. Los directores se reúnen mensualmente para revisar los asuntos de la agencia.
- En la Asociación será cordialmente recibido. Aquí encontrarás consejos profesionales. Además somos veteranos como tú.
- El Centro, es un lugar donde reina un ambiente de cordialidad y amistad. Es fácil para el veterano conseguir ayuda, el único requisito es ser veterano.
- Nadie puede garantizar tu futuro. Ni si quiera la Asociación, pero si sacas el tiempo y haces un esfuerzo por mantener tu participación con el Centro, la Asociación hará todo lo huauante posible para ayudarte. El programa está diseñado para desarrollar confianza y seguridad en ti mismo.
- Los recordados de Vietnam, y otras guerras recientes, aún relatan a los participantes de dichos conflictos belicos. Podeas ayudar a lidar con los conflictos personales de dichas eventos tales como: pesadillas, depresión, sentimientos de soledad, temores, confusión, drogadicción y alcoholismo.
- Servicios Que Se Ofrecen
- Consejería Individual y Familiar
- Orientación sobre temas educativos para los veteranos y familiares
- Orientación en problemas de drogadicción/Alcoholismo
- Referido a Agencias Sociales y otras
- Orientación sobre beneficios al veterano
- Servicio para obtener beneficios de SSI
- Obtención de Record de Servicio Militar
- Referido a servicios de clínicas de veteranos
- Información sobre Agente Naranja
- Referido a Servicios Legales
- Servicios de Notario Público
- Servicio de ayuda de alojamiento
- Servicio de ayuda de empleo



para Referido o Información:

- Puede comunicarse con el Especialista en asuntos de veteranos.
- Horario de la oficina es de lunes a viernes de 9:00 a.m. a 5:00 p.m.
- El Centro es accesible a personas en sillón de ruedas.

**186 MILL STREET
P.O. BOX 70186
SPRINGFIELD, MA 01108
(413) 738-2008
(413) 731-0194**

The memories of Vietnam, and other wars, still bother those veterans who participated in them.

We can help you alleviate personal conflicts such as: nightmares, depression, feelings of solitude, fears, and confusion.

The Association has a Board of Directors who oversee the center. They meet once a month to deal with issues of the agency.

HISTORY OF THE AGENCY

The Puerto Rican Veterans Association of Massachusetts, Inc. open their doors officially in the Commonwealth of Massachusetts on July 1, 1987. The first office was established in Boston. On August 17, 1987, Springfield and Worcester opened their first Outreach offices.

Since then, the Association has been serving veterans in the Commonwealth, we serve all veterans from all wars to the most recent one, Desert Storm.

The Association is one of nine Outreach Centers in the Commonwealth and the only bilingual center.

At the Center, you will be cordially received. Here you will find professional staff that will work with you.

We are also veterans, just like you. The Puerto Rican Veterans' Association of Mass., Inc., is a place with a cordial and friendly atmosphere. It's easy for the veteran to get aid, the only requirement needed is that you be a veteran.

No one can guarantee your future. Not even the Association, but if you take the time and make an effort to maintain participation with our services, the Association will do all that is humanly possible to help you. The program is designed to develop trust and security in yourself.

For Referral/Information:

Contact the Veteran Outreach Specialist to make an appointment.

Open Monday through Friday,
9:00 a.m. until 5:00 p.m.

Center is wheelchair accessible.

HISTORIA DE LA AGENCIA

La Asociación de Veteranos Puerto Ricanos de Massachusetts, Inc. abrió sus puertas oficialmente en Massachusetts el 1 de julio de 1987. La primera oficina fue localizada en Boston. El 17 de agosto de 1987, se abrieron Centros de Alcance en Springfield y Worcester.

Desde entonces, la Asociación ha dado servicios a los veteranos atraves del Estado de Massachusetts, sirviendo a todos los veteranos de todas las guerras hasta de la más reciente, guerra del Golfo Persico.

La Asociación, es uno de nueve centros de Alcance en el estado y el único Centro Bilingüe.

SERVICES PROVIDED

- [Request of Military Records]
- [Individual/Family Counseling]
- [Drug/alcohol counseling]
- [Agent Orange Information]
- [Discharge Up Grading]
- [Disability/Compensation Claims]
- [Legal Assistance Referral]
- [Employment Information]
- [Education Information]
- [Small Business Loans Referral]
- [Housing Referral]
- [Mass Veteran Services]
- [VA Outpatient/Medical Referral]
- [Assistance in applying for SSI]
- [Public Notary Services]

STATEMENT OF H. DAVID BURGE
ACTING CHIEF MINORITY AFFAIRS OFFICER
AND
ACTING ASSISTANT SECRETARY FOR POLICY AND PLANNING
U.S. DEPARTMENT OF VETERANS AFFAIRS

OVERSIGHT AND INVESTIGATIONS SUBCOMMITTEE
COMMITTEE ON VETERANS' AFFAIRS
U.S. HOUSE OF REPRESENTATIVES

SEPTEMBER 28, 1994

Mr. Chairman and Members of the Subcommittee:

It is an honor to appear before this Subcommittee to describe the Department of Veterans Affairs' efforts to improve services to Hispanic veterans.

Secretary Jesse Brown and Deputy Secretary Hershel Gober are committed to ensuring that no veteran is disadvantaged based on race, ethnic, religious, or gender distinctions. This commitment extends to 925,000 Hispanic veterans, over three percent of the veteran population, and is consistent with President Clinton's emphasis on respect for diversity in our Nation.

Mr. Chairman, my remarks today will focus on actions recently accomplished in response to Secretary Brown's direction to fully implement the VA Chief Minority Affairs Officer Act, Public Law 102-218. At the conclusion of my remarks, other VA officials who are with me today and who are responsible for programs of major concern to Hispanic veterans will be pleased to discuss any matters of interest to the Subcommittee regarding their areas of responsibility.

The VA Chief Minority Affairs Act, enacted by Congress in December 1991, requires the Secretary to designate one of the Department's Assistant Secretaries as the VA Chief Minority Affairs Officer (CMAO). The CMAO's primary duties are as follows:

(1) Investigating and examining the policies, regulations, programs, and other activities of the Department as they affect minority group members who are veterans or receive benefits from the Department.

(2) Assessing the needs of minority group members who are veterans or who receive benefits from the Department as those needs relate to the activities of and benefits provided by the Department and to evaluate the manner and extent to which the activities of and benefits provided by the Department fulfill those needs.

(3) Advising the Secretary regarding the effect on minority group members of policies, regulations, programs, and other activities of the Department and of methods to ensure that minority group members are afforded an opportunity to participate fully in the activities and benefits of the Department.

The Act defines minority group veterans as veterans who are Hispanic, Black, Asian American, Native American, Pacific American, or female.

At the beginning of Secretary Brown's tenure as head of the Department of Veterans Affairs, strong Congressional concern was raised regarding the organizational placement and effectiveness of the CMAO's function. Specifically, the past placement of the function in the Office of the Assistant Secretary for Human Resources and Administration was viewed as inappropriate since the CMAO duties were related to minority veterans and not VA employment matters. In addition, little had been accomplished to implement the duties contained in the CMAO Act since its enactment.

Congress recommended that the Secretary reassign the CMAO function to the Office of the Assistant Secretary for Policy and Planning. This recommendation was based on the view that aligning the CMAO function with the policy, planning and statistical functions of the Office of Policy and Planning would strengthen the CMAO effort. Secretary Brown concurred with Congress's recommendation and directed the reassignment in April 1993.

Since that reassignment, much has been accomplished.

- o For the balance of 1993, a CMAO Working Group comprised of representatives from all major VA organizations conducted extensive outreach across the country with representatives of groups and individuals interested in improving services to minority group veterans. These meetings provided the basis for prioritizing areas of highest concern to each minority group. For Hispanic veterans, the priority areas identified were Post Traumatic Stress Disorder (PTSD), language barriers, and improved outreach to Hispanic veterans.

- o In December 1993, VA published the first Chief Minority Affairs Officer Report. The report identified areas of concern, described a broad array of VA activities, and provided key socioeconomic and demographic information for Hispanic and other minority veterans.

o In January 1994, VA established for the first time an Office of Minority Affairs. Mr. Anthony T. Hawkins, a U.S. Army veteran with 28 years of VA service, was selected by Secretary Brown to serve as Executive Director of the Office. Mr. Hawkins has been actively involved in minority veteran issues for five years including a one-year Congressional Fellowship assignment during which he assisted in development of the VA CMAO Act.

o In February 1994, VA established a new Women Veterans Program Office. Secretary Brown selected Ms. Joan A. Furey, who served as a nurse in Vietnam and had 17 years of VA service, as Director of this Office. Most recently, Ms. Furey was the Associate Director of Education at the VA's National Center for PTSD Clinical Laboratory and Education Division at the VA Medical Center in Palo Alto, California. Ms. Furey has been actively involved in women veterans issues for over ten years and helped found the first inpatient PTSD unit for women veterans.

o Over the last six months the Executive Directors of the Office of Minority Affairs and the Women Veterans Program Office have traveled across the country introducing themselves and developing relationships with internal and external groups and individuals interested in minority veteran issues.

o In September 1994, the Secretary approved establishment of a new organizational structure to effectively support the CMAO function. This structure will include a CMAO steering committee in headquarters comprised of the CMAO and representatives from the Veterans' Health Administration (VHA), the Veterans' Benefits Administration (VBA), the National Cemetery System (NCS), and other key offices and a network of minority affairs representatives in field facilities. This structure will ensure that the CMAO function has adequate resources and a means for ongoing communications with local level VA activities, minority veterans groups, and non-VA service providers.

Our accomplishments thus far are as follows:

o Mr. Hawkins visited Puerto Rico to meet with VA Medical Center staff and Puerto Rican veterans concerning allegations of poor medical care and long waiting times for service. He also visited the VA Regional Office and the VA Outpatient Clinic and Vet Center in Ponce. Mr. Hawkins found that the new ambulatory care project approved for FY 1995 would resolve some of the concerns. He fully intends to follow up on the others.

o Mr. Hawkins established a task force comprised of representatives from VHA, VBA, NCS, Consumer Affairs, and Public Affairs to address the issue of language as a barrier to minority beneficiaries obtaining VA services and benefits. We conducted a review of current VA efforts to provide bilingual services and identified gaps and other possible areas where improved service could be provided. The Task Force will form a working group to develop specific recommendations for improved bilingual services. The Working Group on Bilingual Services is expected to be formed and complete its task within the next six months.

o VBA has written an updated summary of benefits in Spanish, and this is now undergoing final review.

o VBA already distributes pamphlets and posters in Spanish on VA's loan guaranty program.

o VHA is surveying all medical centers to determine translation capabilities.

o VHA Pharmacy Service is planning to produce instructions for taking medications in Spanish in geographic areas where Spanish is the predominant language.

o NCS has several Directors of Hispanic origin who do speak Spanish.

o VA's Office of Public Affairs publishes the booklet, "Federal Benefits for Veterans and Dependents" in Spanish.

With regard to the near future, we plan to accomplish the following:

o Designating CMAO representatives in headquarters and the field and establishing the CMAO Steering Committee.

o Using the new CMAO structure to develop specific plans and actions to begin addressing the needs of minority group veterans.

o Enlisting the help of groups and individuals outside VA interested in minority group women issues to refine our plans and to support implementation actions.

Mr. Chairman, we have made significant progress in fully implementing the CMAO Act over the last few months. We have for the first time offices and a supporting organizational structure to start the real task of further identifying and finally removing barriers to VA programs for minority veterans and assessing our current programs in terms of their responsiveness to the needs of these veterans. There is an understandable impatience, which I share, with existing shortcomings; I want to assure this

Subcommittee that, although considerable work will be necessary to make much needed changes, we are working at this with a sense of urgency. Also, we are encouraged because we have the Secretary's full support, and for the first time, dedicated resources to accomplish this task.

This concludes my remarks regarding implementation^{-of} the CMAO function in the Department of Veterans Affairs. I would be happy to answer any questions you or the Subcommittee members may have related to my statement. My VA colleagues would also be pleased to answer any questions you may have in areas of particular interest to you.

STATEMENT OF PRESTON M. TAYLOR JR.
ASSISTANT SECRETARY OF LABOR FOR
VETERANS' EMPLOYMENT AND TRAINING
BEFORE THE
U.S. HOUSE OF REPRESENTATIVES
COMMITTEE ON VETERANS' AFFAIRS
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS

September 28, 1994

Good morning Mr. Chairman and Members of the Subcommittee. My name is Preston Taylor. I am the Assistant Secretary of Labor for Veterans' Employment and Training. I am pleased to appear before you today with this opportunity to discuss issues regarding the employment and training of Hispanic veterans.

Throughout American military history, Hispanic Americans have volunteered to be in uniform, bear arms and place themselves in harm's way to protect American interests. Their courage and willingness to fight for their country is reflected in the black granite of the Vietnam Veterans Memorial where one out of every ten inscribed names is of Hispanic origin. Hispanic veterans, like all veterans, have made the supreme sacrifice and faced peril in the line of duty. They have done so without regard to ethnicity.

Mr. Chairman, Secretary Reich and I are committed to a policy which assures that all returning service members have the opportunity to obtain special employment services, before and after separation. Where the data show that a particular demographic group faces exceptional challenges in finding employment, it is appropriate to focus more attention and resources on that group.

This morning I will first describe the ways in which the Veterans' Employment and Training Service (VETS) assists Hispanic American veterans as we assist all veterans. Later, I will discuss initiatives we are pursuing that will address the high unemployment rate being experienced among Hispanic veterans.

In 1933, the Wagner-Peyser Act was passed establishing the first unified national labor exchange system. This law created a veterans' employment service in each of the state public Employment Service Agencies and acknowledged the need to place a special emphasis on helping veterans find employment.

During World War II, Congress augmented the Wagner-Peyser Act to ensure that unemployed veterans received additional, focused assistance in their search for employment. The Servicemen's Benefits Act of 1944 created the Local Veterans' Employment Representative (LVER) program. Today, this program funds staff positions in more than a thousand local offices of the public employment service systems in the fifty states, the District of Columbia, Puerto Rico and the Virgin Islands. These LVER positions are dedicated to ensuring that veterans receive adequate labor exchange information, referrals to job openings and other employment related services.

More than thirty years later, following the close of another war, the Disabled Veterans' Outreach Program (DVOP) was established in 1977 as part of President Carter's Economic Stimulus Package. At the time, the DVOP was a temporary program designed to improve the quality of services made available to disabled veterans. Emphasis was placed on services to Vietnam-era disabled veterans who were in need of readjustment and employment assistance. In 1980, Public Law 96-466 gave the DVOP permanent program status. This legislation re-emphasized priority of services for disabled and Vietnam-era veterans and broadened the list of activities to be carried out by program staff.

Over the last few years, several million veterans have been served by the DVOP and LVER programs. Last year alone, 1.8 million veterans registered with the Employment

Service, of whom about 114,000 were Hispanic veterans. Over half a million of these registered veterans were helped into jobs by staff funded by the DVOP and LVER programs and other staff of the State Employment Service Agencies.

Now I would like to turn your attention to programs administered by VETS that are targeted to assist groups of veterans that have not been adequately served. The Homeless Veterans' Reintegration Project (HVRP), funded under the Stewart B. McKinney Act, targets employment and training services to veterans who lack both shelter and income. The HVRP is an employment and training focused program with the objective to place veterans into jobs that lead to self-sufficiency. In addition to placement and training activities, participants are given supportive services, such as food and clothing, either directly or through referral to other social services. An evaluation of this program indicated that in Fiscal Year 1992, five percent of the participants served by this program were Hispanic. Since that time, the HVRP appropriation has increased from \$1.3 to over \$5 million and the number of grants funded has increased from 12 to 32. We now have new grants in Texas with the American G.I. Forum, Florida and in California where our effort has tripled from two to six grants. Because of this increased emphasis being made in states having higher than average concentrations of Hispanic veterans, we anticipate that services to homeless Hispanic veterans will be significantly increased. Currently, the HVRP targets services to 8,415 veterans of whom 3,800 will have found employment by the end of the current fiscal year.

VETS also administers programs funded under Title IV, Part C, of the Job Training Partnership Act (JTPA IV-C). Through this program, we have funded demonstration projects that explore different program designs and strategies that may improve the delivery of employment and training services to recently separated, Vietnam era and disabled veterans who are encumbered with exceptional barriers to employment. Typically, these demonstration projects have been operated by community-based organizations which have experience and expertise in assisting specific groups of veterans overcome their barriers to employment. In targeting services to veterans who are "most-in-need", including Hispanic Veterans, VETS has awarded several of these demonstration grants to the American G.I. Forum, the largest organized group of American veterans of Hispanic descent.

For example, in 1988, the American G.I. Forum and seven other grantees were awarded grants to specifically target services to women veterans. Being located in San Antonio, where there are several large military separation centers, the American G.I. Forum was very successful in providing separating minority women veterans with training and employment.

Over a two-year period from 1988 to 1990, the American G.I. Forum, utilizing a VETS' grant, operated a veteran's "Whole Family" program that provided a rich mixture of counseling, training and employment assistance to Hispanic and other minority veterans and their spouses. During the summer and after school, many of the children of these families were also enrolled in youth employment programs. Although costlier than most employment and training interventions, a holistic approach that provides all members of a veteran's family with the resources necessary to become self-sufficient, promises long term benefits in terms of job retention and family stability. Over a two-year period, our current JTPA IV-C grants are expected to provide job skills training to 7,000 veterans. As a result of the success of the demonstration projects VETS has funded, the present JTPA IV-C programs are making a special emphasis to target services to minority and women veterans.

We have also applied some of the insight gained in the Veteran's "Whole Family" concept to the Transition Assistance Program. This program, more commonly referred to as TAP, has increased in both size and effectiveness in order to respond to the circumstances created by the on-going military downsizing. In addition to providing training to separating service members, TAP also instructs the spouses of participating service members on how to find employment in the civilian labor market. In a TAP workshop, service members and their spouses are given labor market information, assistance in developing resumes, and training in the skills, methodologies and practices required to develop a promising job search strategy necessary to obtain a civilian job. TAP is currently available at 204 sites in 43 states and, on average, delivers 300 workshops each month. In Fiscal Year 1993, TAP

provided services to approximately 145,000 participants and, based on enrollments to date, another 160,000 will have been trained by the end of this fiscal year.

We are proud of TAP's success in helping veterans, including Hispanic veterans, find jobs. An evaluation of TAP revealed that service members who participated in TAP workshops found employment approximately three weeks sooner than non-participating counterparts. Because recently separated veterans are at a disadvantage in competing in the civilian job market, TAP is vital to the employment potential of every separating service member.

Current data provided by the Bureau of Labor Statistics indicate that peacetime veterans between the ages of 25 and 34 -- the range that is most typically representative of the recently separated veteran group -- are less likely to find work than are their non-veteran counterparts. The current unemployment rate among peacetime veterans in this age range is 8.8 percent, whereas the rate for their non-veteran counterparts is 6.7 percent.

However, the employment circumstances for recently separated Hispanic veterans, like those for African American veterans, are significantly worse. The unemployment rate among Hispanic veterans in the 25 to 34 year age group is 10.6 percent. We believe that the first step in ameliorating the high unemployment rates among these young veterans is to maximize their opportunities for participation in the TAP workshops. This past summer I convened an inter-agency committee to look into the possibilities of expanding TAP to serve more separates. I have begun to implement initiatives based on their suggestions and findings. In Fiscal Year 1995, we hope to increase participation in TAP workshops by 14 percent.

The current overall unemployment rate among Hispanic veterans (age 20 and over) is 8 percent. The rate among Hispanic non-veterans is 9.7 percent. Although the sample size from which these percentages were derived is too small for us to draw absolute conclusions, we believe that these figures suggest that, like African American veterans, Hispanic veterans are generally more likely to find employment than their non-veteran counterparts. Such a difference in employability would suggest that the training and work experience gained from the military and, perhaps augmented by the specialized services described above, provide a favorable advantage to Hispanic veterans in the job market over their non-veteran peers. However, when compared to the current 5.8 percent unemployment rate found among all veterans, the higher unemployment rate among Hispanic veterans warrants consideration of re-focusing the attention of our primary resources, the DVOP and LVER staff, on these veterans who are most-in-need.

Mr. Chairman, Hispanics are not the only group of veterans among whom we find pockets of relatively high unemployment. As noted in my testimony before this Subcommittee on September 14, the unemployment rate last year for African American veterans was 10.2 percent and the corresponding rate for women veterans was 8.4 percent. In recent times, the unemployment rate among special disabled veterans has generally approximated 8 percent. Inferential and anecdotal information suggests that the unemployment rate is even higher for Native American veterans. To assist these particular groups of veterans who are encumbered with exceptional challenges to employment and further combat these high unemployment rates, we believe a change in the way services are currently targeted in the DVOP and LVER programs is required.

In Fiscal Year 1995, we will initiate a case management pilot study through the DVOP and LVER grants in four states. In this demonstration, case management services will be provided to all veterans who have been assessed and found to have significant barriers to employment. These veterans will be referred to either a specific DVOP or LVER staff person for case management services. In essence, the veteran's case manager will ensure that he or she receives a full range of services that are considered necessary to address the veteran's particular barriers. Further, the case manager will maintain recurrent contact with the veteran on no less than a monthly basis to ensure that he or she is receiving adequate services and is making appropriate progress towards gainful employment. I hope to have the opportunity to appear before you at some time in the future to discuss the results of this four-state study.

Mr. Chairman, Secretary Reich and I are committed to assuring that Hispanic veterans, as well as all veterans, succeed in the civilian workforce. Veterans have earned the right to this special service because of their extraordinary service to this country. We are concerned with high levels of unemployment among Hispanic veterans who are leaving military service. We believe that expanding the TAP program to serve more separates, and directing DVOP and LVER resources to serve veterans who have significant barriers to employment, will increase employment opportunities for our Hispanic veterans.

Thank you for this opportunity to describe some of VETS' employment and training services and our concerns and plans regarding the employment of Hispanic veterans. I would be happy to answer any questions you might have at this time.

U.S. SMALL BUSINESS ADMINISTRATION
WASHINGTON, D.C. 20416

STATEMENT OF

LEON J. BECHET

ASSISTANT ADMINISTRATOR FOR VETERANS AFFAIRS

U.S. SMALL BUSINESS ADMINISTRATION

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS

SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS

SEPTEMBER 28, 1994

Mr. Chairman and members of this subcommittee, I'd like to thank you for the opportunity to appear before you during Hispanic Heritage month to discuss "Hispanic Veterans: Contributions to the Nation and Community, Receipt of Federal Veterans Benefits and Related Issues." My name is Leon Bechet. I am the Assistant Administrator for Veterans Affairs at the Small Business Administration (SBA).

OVERVIEW OF SBA PROGRAMS

The Small Business Administration's veterans program was begun as a result of the Congressional mandate that the SBA give "special consideration to veterans, their dependents and survivors." (Pub.L. 93-237). Based on that mandate, the Office of Veterans Affairs was established on May 14, 1982. During our almost 13 years of existence, we have worked closely with the Veteran Service Organizations and the SBA field and program offices to reach out to veterans who have honorably served our country and who are interested in entrepreneurship. With the current base closings and military downsizing, our services will continue to be valuable to our Nation's veterans.

As the Committee is aware, the SBA offers a number of programs to help small businesses, and all of our programs are available to any veteran who meets the program qualifications. Our programs include financial assistance programs, business counseling programs, our small business investment programs, the disaster assistance loan program, international trade programs, and our minority enterprise development program.

SBA LOAN PROGRAMS

The SBA's principal loan program is known as the 7(a) loan guaranty program, where the Small Business Administration can guarantee loans to small businesses when necessary financing is unavailable on reasonable terms through normal channels. These loans are made

by commercial lending institutions. Under this program, the SBA can guarantee between 70 and 90 percent of a loan, up to \$750,000. In FY 1994, the SBA expects to make approximately \$7.6 billion of 7(a) loans.

In the 7(a) loan program, a small business approaches its bank of account and the bank makes the business a loan with a guaranty from the SBA that if the business defaults, SBA will pay a specified proportion of the principal and interest owed to the bank. This reduces the bank's exposure on the one hand, and because the SBA's guaranty enjoys the full faith and credit of the government, it can more easily be sold on the secondary market. Where funds are available, the SBA also makes direct loans to businesses that cannot obtain funds elsewhere on reasonable terms. Traditionally, the Congress has earmarked a portion of the SBA loan funds for direct loans to Vietnam-era and disabled veterans. The ceiling for direct loans is \$150,000. All loans can be used to establish a small business or expand an existing small business. In FY 1994, the last year of the program, the Vietnam-era and Disabled Veteran Loan Program amounted to a \$12 million veteran loan program. Although there are no provisions in the FY 1995 Appropriation Act for a continuation of this program, we intend to meet the needs of our veteran constituency by renewed emphasis on bank loans to veterans, and by leveraging the guaranty funds available to expand the veteran guaranty loan program to a \$1.75 billion program. Currently the veteran guaranty loan program makes \$1.2 billion of loans per year.

Mr. Chairman, you have indicated your interest in data regarding our loan programs and Hispanic veterans. First, the Census Bureau reports that there are over 422 thousand Hispanic-American owned small businesses in the United States. 17.5 percent of these, or almost 74 thousand, are owned by Hispanic-American veterans. During the current fiscal year, we have made 2,154 loans to Hispanic-Americans totalling more than \$384 million, utilizing the 7(a) program. This figure has more than doubled from the \$170 million total in FY 1991. Hispanic-American veterans received 245 7(a) loans totalling \$44 million in FY 1994.

The Small Business Administration also administers a Development Company Program.

In the Development Company Program there are three players. A private lender advances 50% of the project secured by a first lien. The interest rate to the private lender may be variable or fixed and the term for real estate is ten or more years. The 504 financing made by the Certified Development Company (generally in the form of permanent or take-out financing which would pay off an interim construction loan) covers 40% of the project and is secured by a second lien. This financing varies in amount between \$50,000 and \$ 1 million, with a fixed interest rate. Terms are 20 years for real estate and 10 years for equipment. The borrower must have 10% equity in the project.

We approved \$51 million in development company loans for Hispanic-American firms during FY 1994. This figure is up from \$14 million in FY 1991. Hispanic-American veterans received \$2.3 million in Development Company loans in FY 1994.

OUTREACH AND TRAINING

My office, the Office of Veterans Affairs, devotes much of its effort to outreach for veterans. We want to assist veterans to understand and utilize all of SBA's programs: financial assistance, business counseling, training, surety bonding, and procurement.

In addition to these programs, the SBA has developed outreach and training programs just for veterans:

- The Veterans Entrepreneurial Training (VET) program provides long term in-depth business training to veterans and/or their spouses. There are two VET programs currently in operation. One is being conducted by the New York Veterans Leadership Program and is working with the private sector to provide outreach along with training for veterans wanting to go into business. The program has resulted in 22 business start-ups, and about 6 additional participants are at some stage in the development of their business plans. The second program is being conducted at Central State University in Wilberforce, Ohio, where the University is providing community outreach and has trained 31 veteran-owned businesses in International Trade, CAD/CAM technology, and Procurement techniques.
- A Business Opportunities Conference series, a joint operation sponsored jointly with the Department of Veterans Affairs helps veteran-owned firms and firms impacted by military downsizing sell to federal government agencies, prime contractors and private sources. We have conducted this series in California,

Texas, Colorado, and Connecticut. We target those areas where businesses are affected by base closings and provide training on doing business with the government in addition to putting the participants in contact with personnel from procuring offices who can discuss procurement opportunities with these agencies.

- The Transition Assistance Program, a joint operation with the Department of Defense and the Department of Labor, provides briefings to active duty military personnel who are about to be discharged. Our Veterans Affairs Officers and Service Corps of Retired Executives (SCORE) volunteers have been involved in providing information on the SBA's programs and how to obtain SBA assistance on all bases where we have been permitted access. We will continue this program during FY 1995 utilizing our SCORE representatives to replace Veterans Affairs Officers.
- Our Defense Technology Seminars represent an effort of the SBA, the Naval Surface Warfare Center and the Army Research Laboratory to conduct pilot conferences to assist small firms interested in the commercial applications of defense technology. This pilot conference, aimed at assisting high-tech, veteran-owned small businesses, was highly successful and has lead to a signed agreement to conduct at least four additional conferences during FY 1995.

Further, more than 50 thousand Hispanic-Americans utilized the training and counseling services of SCORE, the Small Business Development Centers (SBDCs) and SBA's other resource partners during this fiscal year. Unfortunately, there is no data on how many of these Hispanic Americans are veterans.

PROCUREMENT ASSISTANCE FOR MINORITY FIRMS

The SBA administers a business development program, the 8(a) program, which utilizes government contracting as a source of revenue for developing strong businesses among the economically and socially disadvantaged. By definition, many Hispanic-Americans have experienced economic and social disadvantage. Many have changed their lot in society through serving in the military, and many veterans participate in the 8(a) program.

There are 5,433 firms in the SBA's 8(a) portfolio, of these 1,369 are Hispanic-American. Thus, Hispanic-American owned firms make up 25% of the SBA's 8(a) portfolio. These firms received \$803 million in 8(a) contracts during FY 1994. Two hundred sixty-two, or about 4% of the total 8(a) firms are veteran Hispanic-American owned.

DEFENSE CONVERSION ASSISTANCE

A special emphasis program is being developed to help defense-dependent firms diversify into commercial markets. The SBA is working on a Memorandum of Understanding with the Department of Defense (DoD) to provide financing to firms affected by defense downsizing. We anticipate the transfer of funds from the DoD to provide for the capitalization of a Defense

Diversification Loan Program in FY 1995. These funds would be used to leverage \$20-30 billion in loan guarantees. In addition, \$3.5 million has already been appropriated for management and technical assistance to these firms through the SBA's Small Business Development Center Program.

CONCLUSION

I hope this information is helpful to your committee. The Small Business Administration is dedicated to helping small businesses grow and prosper. Through our special outreach programs for veterans, our goal is to assist every qualified veteran to utilize all of the SBA's resources and programs to develop successful businesses, and provide jobs for other veterans.

Thank you for this opportunity to testify. I would be pleased to respond to any questions you may have.



Vietnam Veterans Of America, Inc.

Chartered by the United States Congress

Statement of

VIETNAM VETERANS OF AMERICA

Submitted to the

**House Veterans' Affairs Subcommittee on
Oversight and Investigations**

By

Lupe Alviar
VVA National Board of Directors

Oscar Flores
VVA National Minority Affairs Committee

Julio Gonzales
VVA Veterans Service Officer

Vernon Valenzuela
Chair, VVA National PTSD/Substance Abuse Committee

Regarding

***Hispanic Veterans: Contributions to the Nation and Community, VA
Benefits and Services and Related Issues***

September 28, 1994

1224 M Street, NW, Washington, DC 20005-5183

A not-for-profit veterans service organization

Telephone (202) 628-2700 • General Fax (202) 628-5880 • Advocacy Fax (202) 628-6997 • Finance Fax (202) 628-5881

DISCUSSION

Mr. Chairman and members of the Veterans' Affairs Oversight and Investigations Subcommittee, Vietnam Veterans of America thanks you for the opportunity to participate in this hearing, which discusses the much-overlooked issue of the problems faced by America's Hispanic veterans. We are all aware that minorities face an uphill battle to receive needed benefits from the Department of Veterans Affairs (VA). The Hispanic veteran community is sometimes labeled as the silent minority. This may be due in part to language and cultural barriers and/or economic disadvantage. While the VA provides a range of compensation, health, housing and burial benefits to veterans, the plight of Hispanic veterans serves notice that all of these programs are desperately needed, but are rarely accessed by this population.

When any population of veterans uses the VA as little as Hispanic veterans do, something is wrong. Our purpose in providing this testimony is to discuss some specific problems facing Hispanic veterans and present options for addressing these needs. These issues will point to the need for two very basic and broad-based solutions at the outset: a) VA should become more user-friendly for Hispanic veterans and veterans of other cultures and/or languages; and b) VA must do more outreach into the Hispanic and other minority communities.

Military service for the citizens of this nation has always served to promote the cause of equality for all of us, and has provided minority populations an avenue to gain training, employment and health care. For Hispanic veterans, military service sometimes provides an avenue to legal employment in the U.S. (a green card) or citizenship. For generations, Hispanics have served with pride and are now often too proud to ask for assistance from the nation for which they committed their very lives.

Mr. Chairman, your work with the Congressional Black Caucus and its Veterans Braintrust has improved the services for minority veterans. We are hopeful that today's efforts will forge a similar partnership between this Committee and the Congressional Hispanic Caucus, to press for a better future not only for ourselves and our Hispanic sons and daughters -- but also for our veterans who are African-American, Asian, Native American, white, or otherwise. VVA also wishes to publicly thank Representatives Luis Gutierrez and Frank Tejeda for their initiative and commitment to this cause. We look forward to ongoing collaboration on these issues to improve VA services for all veterans.

VVA AND MINORITY VETERANS

We are here today to discuss the treatment of Hispanic veterans who have served in the U.S. armed forces since the birth of this nation. Many Hispanics fought against their own distant cousins during the Texas-Mexican War to defend the Alamo and help annex the State of Texas. Hispanic veterans have always proudly contributed to America's defense but still, after returning from war, were denied equal treatment and honor. Many were not allowed to eat in our public restaurants. Even those who received the nation's highest award, the Medal of Honor, were denied the very rights they had so valiantly fought to defend. It is important to note that Hispanics hold more Congressional Medals of Honor per capita than any other ethnic group or race -- they have proven themselves to be the backbone of America's defense of freedom and prosperity. Nineteen percent of the Hispanic population served, even though Hispanics only comprised 4 to 5 percent of our nation's population during that era.

The nature and history of VVA engendered the basis for its mission of advocating on behalf of underserved veterans. The Vietnam generation of veterans experienced treatment by our society as a separate class of veterans, and these veterans came from a wide range of social, economic, ethnic and racial backgrounds. This problem is magnified for minority veterans.

Vietnam Veterans of America is the only national Congressionally-chartered veterans organization, exclusively dedicated to Vietnam-era veterans and their families. VVA's goals are to promote and support the full range of issues important to all Vietnam veterans, to create a new identity for this generation of veterans, and to change public perception of Vietnam veterans.

VVA has always promoted itself as an inclusive rather than exclusive organization. We have prided ourselves on the fact that we are an organization whose strength lies in the diversity of its membership. Our mission is to assist veterans who served during the Vietnam-era without regard to race, creed, color, religion, sex, sexual preference or national origin. The VVA National Board of Directors has had a Minority Affairs standing committee since 1985.

The problems of Hispanic veterans are not necessarily unique from that of other veterans, but are simply more pronounced. For this reason, VVA does not advocate for an entirely new slate of unique "Hispanic veteran" programs within the VA -- a more practical, inclusive approach would simply ensure that Hispanic veteran communities are knowledgeable of and able to access the services for which they are currently eligible. To reiterate, VA should become user-friendly to Hispanics and conduct significant and effective outreach. VA needs to make more of an effort to address the "unique" Hispanic veterans community's "common" problems, and not assume that these problems are too vast to correct.

LANGUAGE AND CULTURAL BARRIERS

Perhaps the most significant and at the same time overlooked reason that Hispanic veterans do not access needed services -- programs for which they are rightfully eligible -- is the language and cultural barriers that exist in the mammoth VA bureaucracy. There is a need to have bilingual and/or multilingual staff available at all VA facilities and offices. Additionally, benefits information and other materials should be printed and available in Spanish and other appropriate languages. VVA Convention Resolution MS-2-93 speaks to this issue. These are relatively simple and logical steps to assist these veterans.

Many Hispanic veterans do not utilize VA services which they need and are eligible for simply because they cannot get information about how to access these services. Often they simply do not ask because they are embarrassed about poor English-language skills and are intimidated by the system. Once Hispanic veterans pass this first barrier, we are likely to see a more proportionate number using VA programs and services.

Another important cause of Hispanics underutilization of VA services, in addition to the language barrier, is that many are simply unaware of the services available. We have observed that they are also very trusting of and intimidated by the federal government. If they ask for assistance once and are denied, they don't go back. Hispanic veterans don't know what services they are eligible for, and they don't know that VSO service representatives can help them navigate the system. VA and VSOs need to conduct extensive outreach and education for this community.

A final point to consider when evaluating why Hispanics don't access the VA system is the extreme shortage of facilities and services in the heavily Hispanic populated areas of the country. South and West Texas, for instance, are served only by an outpatient clinic. Some Hispanic-American veterans reside in Mexico, where their benefit dollars provide a higher standard of living. Those in this area needing inpatient care must travel a significant distance to a VA facility. The total number of Hispanic veterans suggests the need for more VA services, outreach and education of the public. We note that there is also a significant shortage of veterans cemeteries in this region. Surprisingly, this very large population of veterans -- most of whom are Hispanic, does not seem to have enough political strength to get attention or solutions for their needs. This must change.

PTSD AND SUBSTANCE ABUSE

Post Traumatic Stress Disorder (PTSD) is perhaps the most common major contributor to chronic mental illness among veterans of any generation. According to the highly respected National Vietnam Veterans Readjustment Study (NVVRS), published in 1988 by the Research Triangle Institute, approximately 30 percent (830,000) of the veterans who served in Vietnam suffer significantly from PTSD, and nearly half a million men and women suffer from full-blown PTSD. The study found the highest rates of PTSD and readjustment difficulties was among Hispanic veterans.

PTSD is a chronic disorder in itself, not limited to Vietnam veterans but afflicting many who served in every war, as well as people who have experienced a wide variety of other traumatic stresses. NVVRS found that veterans with PTSD have an increased likelihood of suffering other specific psychiatric disorders and a wide variety of other post-war readjustment problems, including alcohol and drug abuse, incarceration, homelessness, unemployment and underemployment. This again is disproportionately evidenced among minority populations.

VVA endorsed your legislation, Mr. Chairman, and the companion bill sponsored by Senator Daniel Akaka in this Congress, which would improve access to service and modalities of PTSD treatment. We are hopeful that this legislation will soon be signed into law. This legislation proposes a pilot project to co-locate VA Outpatient Clinics with Vet Centers. We have seen that many veterans afflicted with PTSD -- particularly Hispanics -- do not trust the bureaucratic agencies of government, and therefore do not seek general health care services at VA Medical Centers. This is especially troublesome because these veterans are often uninsured and cannot obtain health care elsewhere. Co-location of medical personnel with Vet Centers could greatly enhance minority veterans access to health services.

Treatment of PTSD in Hispanics is a useful example to further develop VA's need to be "culturally sensitive." Because of the rather machismo image of Hispanic men within their own community, many are reluctant to seek needed mental health services. Some counselors find it useful to confront the cultural issues directly. VA needs to be aware that culture incorporates values and beliefs, which are particularly important in treating PTSD in Hispanic veterans.

Often, a family member will bring a suffering Hispanic veteran to a Vet Center for counseling. Normally, a counselor would discourage this because treatment has the greatest chance of success if the individual recognizes his or her needs and seeks help independently. Hispanics, because of their

community values, frequently seek assistance from a *curandera* or folk healer before taking the negative or desperate route of mental health care, which creates the perception that the veteran is crazy. It is particularly important that Hispanic veterans' families are incorporated into the treatment process to erase the notion that he or she is crazy, and to maintain the solidarity of the family's trust.

Most importantly, it is vital that mental health therapists be bilingual/multilingual. Without a feeling of comfort, understanding and inclusion, veterans suffering from PTSD are unlikely to feel safe enough to leave the "ego" undefended. "Defending ego" is a normal human reaction -- and is a basic survival instinct for anyone suffering from PTSD. Language and cultural sensitivity reaffirm the patient's perception that it is o.k. to be vulnerable. This is a vital step in resolving inner-conflict associated with trauma.

HOMELESS AND ECONOMICALLY DISADVANTAGED VETERANS

Another troubling consequence of the veterans' vicious circle of PTSD, substance abuse and continuing readjustment problems is the high rate of homelessness. Veterans represent between 30-50 percent of the homeless. According to figures supplied by the Department of Housing and Urban Development (HUD) in *The Federal Plan to Break the Cycle of Homelessness*, minority veterans comprise some 40 percent of homeless veterans. Veterans are heavily over-represented among the homeless, and minority veterans make up more than their fair share of that population.

Many minority veterans returned during turbulent periods of the civil rights movement to poverty-stricken, drug- and crime-infested neighborhoods. Thus, with no respite from a war zone atmosphere, it is only natural that significant numbers of Hispanic veterans became displaced due to readjustment problems.

The reasons for homelessness are many and the causes of homelessness among veterans are similar to the reasons for homelessness among non-veterans. Unfortunately, the nation has failed to address in any comprehensive fashion the root causes of homelessness in America.

The needs of homeless and economically disadvantaged veterans cannot be fully addressed through appropriately designed national policies until the veterans and others within these populations are identified, accurately counted, and assessed. Whether homelessness is a result of structural unemployment, deinstitutionalization of mentally ill, urban gentrification, economic dislocation or the complete deterioration of the nation's stock of low to moderate income housing, the nation has an undeniable obligation to take corrective steps to ameliorate homelessness.

Vietnam Veterans of America applauds the development of a comprehensive national policy to address homelessness and the plight of the economically disadvantaged. However, any federal plan to break the cycle of homelessness should proceed from an accurate assessment of the size and various components of the problem. Once these populations are counted and assessed, the policy developed should encompass all facets, including housing and urban planning, secondary education, rehabilitation, crime control, mental illness, substance abuse, unemployment and underemployment and any other current trends contributing to the ongoing disintegration of American society.

VVA chapters and State Councils have been very active in projects to assist homeless veterans. Additionally, VVA has advocated strongly for legislation to address homelessness. VVA has also been a strong proponent of VA increasing its use of refinancing to prevent foreclosure on veterans' VA guaranteed home loans.

ECONOMIC READJUSTMENT

Vietnam veterans, particularly combat theater veterans, disabled veterans and minority veterans, continue to experience significant unemployment and underemployment problems. Discrimination against both combat veterans and members of minorities puts Hispanic veterans in a double bind. These employment difficulties persist in spite of the training, skills, abilities and discipline acquired while serving in the uniformed services.

The "last hired, first fired or laid off" phenomenon in the work place has been one impediment to employment security. The collapse of the heavy industrial and manufacturing sectors of the economy is another. The failure of the Vietnam-era GI Bill to yield sufficient benefit levels to permit completion of academic training programs is yet another such obstacle. Added to this, the federal employment and training programs approved by the Congress have been of too short duration, improperly administered or so restrictive as to be of any real value.

Vietnam Veterans of America is committed to promoting meaningful employment and training programs for veterans, particularly Vietnam and other combat theater veterans, disabled, women and minority veterans. We encourage efforts in both public and private sectors at the national, state and local levels to provide the skills and assistance needed to obtain and sustain meaningful employment at a decent living wage with adequate benefits.

The median income for Hispanic veterans is far less than that of their white counterparts. Hispanic male veterans have a significantly lower labor market participation rate and a significantly higher unemployment rate. This accounts for at least some of the disparity in income between whites and Hispanics. The disparity in objective measurement of economic well-being of Hispanic veterans versus their white counterparts is one that is long-standing in nature, and has not lessened appreciably in the last twenty years.

The connection between readjustment and employment has long been clear. Studies suggest a correlation between significant readjustment problems and inability to sustain meaningful employment. This is particularly significant given that an increasing proportion of the U.S. military forces are drawn from minority groups. Large numbers of these men and women serve in the combat arena and are most likely to be exposed to situations that can lead to significant post-service readjustment problems, including PTSD.

We must focus on the steps Congress and others can take to address and hopefully reverse this disparity in the ability of Hispanic veterans to secure vitally needed services that will enable them to obtain and sustain meaningful employment, strengthening the fabric of our economic life and our communities. While we are not prepared to offer prescriptive solutions that would "solve" these problems, we would like to offer recommendations or fruitful areas of inquiry and/or action.

Education

Vietnam Veterans of America supports legislation to reconfigure the Montgomery GI Bill into a more viable readjustment program by elevating benefit levels to cover the complete cost of tuition for up to 128 credit hours at any accredited public institution of higher learning in any U.S. jurisdiction. This benefit should be made available to members of the military service released from active duty or reserve components subsequent to May 7, 1975, and who served any part of such active duty or reserve service in a hostile fire zone of operations.

Veterans and Small Business

Hispanic veterans who rely on the Small Business Administration (SBA) for guidance and assistance to launch small business enterprises are consistently undercapitalized. A succession of SBA Administrators have demonstrated an inconsistent commitment and failure to implement statutory requirements that veterans be given "special consideration" in their applications for loans or loan guaranties.

Vietnam Veterans of America seeks legislation and administrative action to fortify the SBA's ability to lend small business assistance to veterans in a meaningful way. This should include a definition to the current vague requirement that SBA provide "special consideration" for veterans, and should require its implementation. Additionally, Congress should promote the redevelopment of Veterans Business Resource Councils around the nation to offer guidance and counseling to veterans either already in or about to begin small businesses.

VA Home Loan Program

Over the last 12 years, legislated changes in the VA home loan guaranty program, designed to effect reduction in the federal deficit have made it increasingly unavailable to those Hispanic veterans most deserving of this program, first-time home buyers. The VA home loan program has been in steady decline for many years. Ill-advised sales of the program's income-generating home loan portfolio, rising foreclosure rates owing to periodical deep recessions and the addition of user fees for individuals in the program have all contributed to making the program extremely unattractive for some and unusable for many others.

Vietnam Veterans of America supports legislation removing the imposition of user fees on first-time home buying veterans and mandating aggressive VA loan servicing for veterans in or near default so as to diminish foreclosures that threaten the program's solvency.

Veterans Employment Preference

Far from being understood as a means of reinforcing affirmative action hiring, veterans preference has come under a divisive attack which places those who served in the military and those who did not on opposing sides. Veterans preference in civil service hiring has been statutorily required for so many years that it is assumed to be working well. Unfortunately, federal agencies have found numerous ways to

side-step veterans preference laws. The result is that only those agencies with a clear interest in veterans feel compelled to utilize veterans preference as a guiding policy for use in hiring.

Vietnam Veterans of America urges the establishment of a Congressionally-mandated review of current personnel policies used by the Office of Personnel Management (OPM) and the various federal agencies with a view toward ascertaining what legislative changes in veterans preference laws are needed to make them current and enforceable throughout the federal government.

Employer Incentives for Hiring/Retraining Veterans

As a result of general transformation of the nation's economy over the last 15 years, the middle income jobs often filled by minority veterans in the heavy industrial and manufacturing sectors have nearly disappeared from the economic landscape. Millions of new service industry jobs have been added to the economy, but these jobs only rarely offer displaced veterans salary levels equal to those available in jobs eliminated by economic transformation. Hispanics, even when they are veterans who have served this nation in time of peril, are frequently among the "last hired, first fired."

While we have made some progress in securing gains in both the quantity and quality of services available to veterans under Title IIA of the Job Training Partnership Act (JTPA) and under Title III of the JTPA (also known as the Economically Dislocated Worker Adjustment Assistance Act or EDWAA), there is no requirement in the Job Training Partnership Act or other significant federal programs which specifies priority service for any veterans, much less minority veterans.

Against this background, federally-sponsored training programs have ignored minority veterans by failing to target them in programs such as the Job Training Partnership Act (JTPA). Even if targeting of veterans in JTPA were undertaken, however, more would need to be done to encourage employers to hire veterans into training or regular employment positions with legitimate career growth potential. The most reliable way of encouraging employers to do so is through the use of tax incentives.

Since many veterans are faced with pressing basic survival needs, they find it difficult to enter into classroom training. The new JTPA rules make it much more difficult for on-the-job training (OJT) opportunities to be structured under EDWAA and Title IIA of the Job Training Partnership Act. The Service Members Occupational Conversion Training Act (SMOCTA) is a very exciting priority program for recently separated veterans. We believe that it should be extended, if not made permanent as a new entitlement under the Montgomery GI Bill. It is worth noting that 49% of those who used the WWII, Korea, and Vietnam GI Bills, used it for OJT, vocational training, or apprenticeship. Such an OJT program would be useful, particularly for Hispanic veterans in light of the income disparity previously noted, and the need to earn an income while training. Minority veterans need to be able to survive while they acquire skills which will lead toward career-oriented employment. Often the only way to do this is with a structured on-the-job training program.

Vietnam Veterans of America supports the creation and retention of tax incentives designed to generate employer-provided training, educational and employment opportunities leading to meaningful careers.

Transition Assistance to Separating Veterans

Hispanics separating from the military need assistance to effectively join the civilian labor market. To achieve proper transition services for these separating veterans requires excellent communication, cooperation and coordination among all public and private entities. To deal with the special problems of those leaving the military earlier than anticipated, Congress enacted Public Law 101-510 in late 1990. The Secretaries of Defense, Labor and Veterans Affairs were directed to fully cooperate to provide employment assistance, family support and other measures to assist these persons and their families. Their efforts have been disjointed, fragmentary and uneven from service to service and even location to location. The nation cannot afford duplication and inefficient services at high dollar costs nor can it waste the opportunity to fully utilize the discipline and skills of the separating veterans in the civilian economy. Vietnam Veterans of America calls upon the President, the Secretaries of Defense, Labor and Veterans Affairs to strengthen our services to the men and women affected by cutbacks.

Viable Labor Exchange System

It may prove to be of particular benefit to Hispanic veterans if a great deal more attention and emphasis is directed toward ensuring that the elements of the U.S. Department of Veterans Affairs, specifically the Readjustment Counseling Service (Vet Centers) and Vocational Rehabilitation, were truly functioning in a collaborative and active way with the U.S. Department of Labor funded state employment security agencies (particularly the Disabled Veterans Outreach Program) on the needs of the veteran customer at the operational level.

Full funding of the Disabled Veterans Outreach Program and Local Veterans Employment Representative Programs to the number of Full-Time Employee Equivalents (FTEE) mandated in Chapter 41, Title 38, United States Code would be of significant help in providing more effective assistance at the service delivery level. These programs have been critically underfunded for the past three years. While reduction in veterans staff has not been as dramatic, it has diminished the overall resources available, creating a negative impact on veterans as well as non-veterans.

CONCLUSION

There is a very real temptation to create separate groups and programs to address the specific problems of minority veterans. VVA recommends that it is important to thoroughly examine and research these distinctive issues relevant to Hispanic veterans. We are also convinced that this should be done to improve VA programs as a whole, rather than to create Hispanic readjustment programs separate from African-American, Native American, Hispanic and women veteran policies.

As indicated, the feeling of inclusion is essential in the treatment of Post Traumatic Stress Disorder and the challenges of readjustment. In addition, it must be realized that outside of the aging World War II community, minority veterans are currently the more likely users of VA programs. Again, this is because of the rates of poverty, more extensive casualties, and readjustment difficulties faced by minorities that we have outlined throughout this testimony. While the plight of Hispanic veterans indicates that they have greater difficulty in the readjustment process, this is not an indication of a lesser ability to acclimate. Hispanics simply need a pronounced and targeted VA and VSO outreach to learn about veterans benefits. They also need assistance in surmounting the language and cultural barriers which often prevent successful quests for benefits.

To improve veteran programs as a whole will not impede progress on minority veterans issues, but will further the goals of bringing these individuals back from the military as contributing members of society and that of providing the recognition and gratitude they deserve for their sacrifice and service to this nation.

Mr. Chairman, this concludes our testimony.

TESTIMONY OF HERO STREET MEMORIAL COMMITTEE
HOUSE OF REPRESENTATIVES
VETERANS' AFFAIRS SUBCOMMITTEE ON INVESTIGATIONS
SEPTEMBER 28, 1994

Hero Street is a small midwestern street in Silvis, Illinois, that holds a special place in Hispanic heritage and American military history. During World War II, Korea and Vietnam this one block area sent 87 sons, brothers and fathers into conflict, more than any other place of comparable size in the Untied States. During the past 50 years, over 100 young men and women from Hero Street have served in the U.S. Armed Forces. Children of the families keep joining the military to this day.

Eight of the young men made the ultimate sacrifice, their lives, and never returned from the battlefields of World War II and Korea. They were Sgt. Claro Soliz, Pfc. Frank Sandoval, Pfc. Joseph Sandoval, Pfc. Joe Gomez (who earned a Silver Star) died in 1950 in Korea after having served in World War II, Pfc. Peter Masias, Pvt. William Sandoval, Pfc. Johnny Munoz and Sgt. Tony Pompa, who enlisted under an assumed name because he was not a U.S. citizen.

The dream of a better life brought Mexican Americans to Silvis, Illinois, to work for the Rock Island Railroad. At first the families lived in boxcars on railroad property. In the 1930's they moved to an area on the west end of Silvis, and built homes on Second Street. There a new generation of Mexican Americans were born and raised by parents who taught them to work hard and fight for their country. When World War II started, they went without hesitation in defense of the honor and ideals of their country.

To honor the sacrifice of the eight young men who lost their lives, and the many who served in the armed forces from the area, in the 1960's Silvis Alderman Joe Terronez conceived and spearheaded a drive to honor the history of Second Street by giving it a new name: Hero Street. He also had two other objectives. A practical one, to have the street paved; and a historical one,

to build a memorial park to honor the soldiers and their families.

Today, Second Street is called Hero Street USA, and it is paved. Atop Billy Goat Hill, where all those soldiers, their friends and families played as "children, stands a temporary monument, built to honor all the veterans of World War II, Korea and Vietnam.

The story of Hero Street has been featured on television and the printed media. Anheuser-Busch won an American Film Festival Award for its video documentary, Hero Street USA. A five page tribute in People magazine and stories in hispanic magazines and Readers Digest have all chronicled the story of Hero Street USA.

To honor the eight brave young men who gave the ultimate sacrifice for their country the Hero Street Monument Committee is seeking funds to construct a permanent monument to serve as a tribute to all American veterans who served proudly in the military forces of the United States. The non profit committee is requesting donations to help make the memorial on Hero Street a reality.

Hero Street USA clearly depicts the gallant contributions made to the defense of America's national security and to the community by Hispanic Americans. The following 102 veterans from Hero Street are proud to have served their country.

GUADALUPE "SONNY" SOLIZ, PRESIDENT

HERO STREET MEMORIAL COMMITTEE

P.O. BOX 124

SILVIS, ILLINOIS 61282

1-800-856-5900

309-755-5900

HERO STREET VETERAN'S

BELMAN, DAVID	AIR FORCE
BELMAN, JESS	NAVY
BELMAN, LOUIS	ARMY
BELMAN, JULIAN	ARMY
CEDILLO, TONY	ARMY
CEDILLO, VICTOR	ARMY
GARCIA, ADOLPH	NAVY
GARCIA, FRANK	NAVY
GARCIA, JIM	ARMY (DECEASED)
GARGANO, CARL	NAVY
GARGANO, JOSEPH	ARMY
GOMEZ, ART	ARMY (DECEASED)
GOMEZ, JOSEPH	ARMY (DECEASED) **
GOMEZ, ROBERT	ARMY
GOMEZ, GUADULUPE	MARINES (ACTIVE)
GOMEZ, RUDY	ARMY
GOMEZ, TOM	ARMY
HERNANDEZ, RAYMOND	AIR FORCE
HERNANDEZ, CECIL JR	NAVY
HERNANDEZ, FRED	ARMY
HERNANDEZ, DAN	ARMY
HERNANDEZ, JOSEPH	ARMY
HERNANDEZ, MIKE	AIR FORCE
HERNANDEZ, ANTHONY	JR ARMY
HERRERA, MANUEL	NAVY (DECEASED)
MANRRIQUE, ERNIE	ARMY
MANRRIQUE, VINCE	ARMY (ACTIVE)
MARTINEZ, MIKE	MARINES
MASIAS, JESS	ARMY
MASIAS, JOHN	ARMY
MASIAS, PETER	ARMY (DECEASED) **
MOLINAR, GREGORIO	ARMY
MONTEZ, BENNIE	NAVY (DECEASED)
MONTEZ, MANUEL	ARMY
MUNOS, JOSEPH S	MARINES
MUNOS, JOHNNY	ARMY (DECEASED) **
MUNOS, JOSEPH	NAVY
MUNOS, ROBERT	NAVY
MUNOS, ART	ARMY
MUNOS, RICHARD	NAVY
MUNOS, THOM	ARMY
MUNOS, MARY ESTER	AIR FORCE
NACHE, MILO	ARMY
NACHE, JESS	ARMY
ORTIZ, ANDY	ARMY
ORTIZ, RUSSELL	ARMY (RETIRED)
PATRONAGIO, GEORGE	ARMY
PATRONAGIO, MIKE	ARMY
PATRONAGIO, JOHN	NAVY
PATRONAGIO, JOSEPH	ARMY (DECEASED)

HERO STREET VETERAN'S (CON'T)

POMPA, HENRY	ARMY
POMPA, FRANK	ARMY
POMPA, TONY	ARMY AIR CORPS (DECEASED) **
RAMIREZ, JOSEPH	ARMY
RAMIREZ, LOUIS	ARMY
RAMOS, BENITO	ARMY (DECEASED)
RAMOS, EDWARDO	ARMY
RAMOS, JOSEPH SR.	ARMY
RAMOS, RUDOLPH	ARMY
RAMOS, JOSEPH JR	MARINES (ACTIVE)
RAMOS, MANUEL	ARMY
REYES, ANGEL JR	AIR FORCE
REYES, MATTHEW	ARMY
RIVAS, RAY	NAVY
SANDOVAL, ALPHONSE	ARMY
SANDOVAL, CHARLIE	NAVY
SANDOVAL, FRED	ARMY
SANDOVAL, OSCAR	NAVY
SANDOVAL, RUBEN	NAVY
SANDOVAL, HARRY	NAVY
SANDOVAL, EDMUND	ARMY
SANDOVAL, FRANK	ARMY
SANDOVAL, EDWARD	ARMY
SANDOVAL, EMEDIO	ARMY
SANDOVAL, TANILO	ARMY
SANDOVAL, SANTIAGO	ARMY (DECEASED)
SANDOVAL, FRANK	ARMY (DECEASED) **
SANDOVAL, JOSEPH	ARMY (DECEASED) **
SANDOVAL, WILLIAM	ARMY (DECEASED) **
SAUCEDO, FRED	MARINES (DECEASED)
SAUCEDO, JOHN	NAVY
SEGURA, DON	ARMY
SEGURA, LUZ	ARMY
SOLIZ, CLARO	ARMY (DECEASED) **
SOLIZ, ANTHONY	ARMY
SOLIZ, FRANK	NAVY
SOLIZ, GUADULUPE	AIR FORCE
SOLIZ, MARGARITO	ARMY
SOLIZ, PAUL	NAVY
SOLIZ, TANILO	NAVY
SOLIZ, CIARO	ARMY
SOLIZ, THOMAS	ARMY
STUDEN, NICK	ARMY (DECEASED)
TERRONEZ, JULIAS	NAVY (DECEASED)
TERRONEZ, LEONARD	AIR FORCE (RETIRED)
TERRONEZ, MATTHEW	MERCHANT MARINE
TERRONEZ, MANUEL	NAVY (DECEASED)
TERRONEZ, MIKE	AIR FORCE
ZEGARAC, WALTER	ARMY
SAUCEDO, LUZ	ARMY
KNOX, DAN	ARMY
KNOX, HARRY	ARMY

STATEMENT:
THE CHAMORU VETERAN
ROBERT A. UNDERWOOD
September 28, 1994

MR. CHAIRMAN:

I want to commend you for holding today's hearing. Our veterans have given this nation the gift of freedom and it is imperative that we return the favor by giving them the respect and resources they deserve. However, America is a multi-faceted community and our veterans reflect the patchwork quilt that is our nation. Therefore, the programs this Congress enacts and the President administers must be sensitive to the special needs of each ethnic, racial, and religious community represented in veterans' ranks. Hispanic veterans deserve such sensitivity, including the Chamorus of Guam.

The people of Guam have made the supreme sacrifice to this nation for generations. In World War II, we were the only American community occupied by the Japanese. Many civilians were murdered at the hands of the occupiers. When the Battle of Guam commenced, Chamoru civilians fought with the American liberators to free the island and turn the tide toward victory in the Pacific. Those Chamorus deserve the thanks and the benefits they deserve.

After Guam's liberation, our sons and daughters joined their stateside counterparts whenever duty called. In the Korean War, Chamorus went to the front and fought for their country. In the Vietnam War, our people responded to the call to duty in the Army, Navy, Air Force, and Marines. Many of our children did not return from these conflicts. But for those who did, they live with the pride that comes only from defending their flag and their country.

And in recent times, sons and daughters of Guam served in Grenada, Panama, the Persian Gulf, and as we speak, Haiti. The people of Guam have stood by their country and always will.

Mr. Chairman, as you can see, the veterans of Guam are like veterans from all over the United States. The veterans of our island deserve the same benefits we bestow upon veterans from all over the nation. In particular, we want to make sure that our veterans receive adequate health benefits. On Guam, health providers are a precious commodity. Often, veterans must be flown to Hawaii for care. We need to make sure that those veterans get the same benefits as their mainland counterparts.

Thank you once again, Mr. Chairman, for your attention to this critical subject. I look forward to working with you on this and other issues regarding the Chamoru veteran.

QUESTIONS SUBMITTED BY
HONORABLE LANE EVANS, CHAIRMAN
SUBCOMMITTEE ON OVERSIGHT & INVESTIGATIONS
COMMITTEE ON VETERANS' AFFAIRS

HISPANIC VETERANS: CONTRIBUTIONS TO THE NATION AND COMMUNITY,
RECEIPT OF FEDERAL VETERANS BENEFITS AND RELATED ISSUES

SEPTEMBER 28, 1994

QUESTIONS FOR MR. H. DAVID BURGE
ACTING CHIEF MINORITY AFFAIRS OFFICER
AND
ACTING ASSISTANT SECRETARY FOR POLICY AND PLANNING
DEPARTMENT OF VETERANS AFFAIRS

Question 1: How has Hispanic Heritage Month been recognized by and throughout VA?

Answer: Secretary Brown issues an all station letter to Administration Heads, Assistant Secretaries, Other Key Officials, Deputy Assistant Secretaries, and field facility Directors informing them of the observance, highlighting the national theme and providing suggestions on activities that would enhance the observance.

Field facilities and Central Office components present individual programs that capture the theme of the observance, and they sponsor activities and speakers addressing issues and concerns of the Hispanic community. For example, VA Central Office invited Dr. Fernando M. Torres-Gil, Assistant Secretary for Aging, Department of Health and Human Services, to be the keynote speaker during the celebration of Hispanic Heritage Month. Dr. Torres-Gil spoke on aging issues affecting Hispanics. Awards often are presented during the Hispanic Heritage Month observance to VA employees who have made significant contributions enhancing the VA Hispanic program.

The Deputy Assistant Secretary for Equal Opportunity and the National Hispanic Employment Program Manager are often invited to be the keynote speakers at field facilities.

The National Hispanic Employment Program Manager also conducts training on the duties and responsibilities of field Hispanic Program Managers during his field visits.

Question 2: Several witnesses noted the importance of family and testified the needs of veterans cannot truly be met without addressing family concerns.

Testimony submitted to the Subcommittee earlier this year by VA stated, "Vietnam veterans' problems stemming from post traumatic stress are not just individual, they impact the entire family. The fallout frequently is on the children - creating a dysfunctional home environment for all. Left untreated, the pattern can repeat itself leaving behind a legacy of impaired interpersonal relationships with children and spouses."

What is VA doing to help families at high risk for developing problems stemming from a veteran's service-connected PTSD? What more can VA do? (With new authority?)

Answer: The value and importance of providing treatment and social support to the families of veterans with PTSD has been established by clinical practice as described in testimony such as that quoted above. The importance of family issues is a standard feature of VA's clinical PTSD training. While VA has the authority to provide clinical services to families as

"collaterals" to the treatment of an identified veteran patient, at times, such as with the passage of Public Law 102-405, VA has been able to expand the scope and volume of its services to veterans' families.

Public Law 102-405 authorized the Secretary of Veterans Affairs to provide marriage and family counseling to veterans awarded a campaign medal for active duty service during the Persian Gulf War and for veterans who were members of reserve components called or ordered to active duty during the war. Spouses and children of these veterans were also covered for services.

The Persian Gulf Family Support Program (PGFSP) was developed by the Department of Veterans Affairs to provide the services authorized by P.L. 102-405. PGFSP was characterized by aggressive community outreach to Persian Gulf War veterans and their families, coordination with national guard and reserve units, and clinical services. These marriage and family counseling services were provided by case managers using services available at VA medical centers, vet centers, and community agencies. The legislation also allowed services to be provided through a contract program with non-VA providers. PGFSP emphasized and used families' strengths as resources for intervention.

Many Persian Gulf War veterans experienced personal, family and social problems after the war. Some problems have continued over time, but others are delayed crises, resulting from cumulative effects of such war-related stresses as financial difficulties, family disruption, psychological and physical trauma, and social network disruption. With the continuing and delayed problems and difficulties anticipated because of downsizing in the active duty and reserve forces, continuing support will be necessary for military families to adjust to these changes.

While the PGFSP authority has expired, VA employees continue to provide clinical support services. In addition, they will continue to network with community providers of social services for referral for services that VA does not have the capability to provide. In making such referrals, VA clinicians will make use of whatever other resources and non-VA entitlements families may have to supplement those available through VA.

Question 3: Please respond to Mr. Martinez's concerns about problems Hispanic veterans have securing employment with VA.

Do VA facilities routinely contact local community-based and social organizations when a job vacancy occurs?

Answer: The Secretary's commitment to a diversified workforce is evidenced by directives issued since February 1993. VA employs 4,436 Hispanic veterans, representing more than 6.5% of all veterans employed in the Department of Veterans Affairs.

The Deputy Assistant Secretary for Human Resources Management (HRM) has also issued quarterly HRM Letters on veterans employment. In several of these letters, he has encouraged local Human Resources Management Officers to reach out to veterans service organizations and other community-based organizations in order to expand employment opportunities for veterans in VA.

VBA recruiters work with Hispanic organizations to inform them about employment opportunities and receive applications from potential candidates. Many VBA facilities have counselors who are fluent in Spanish and who are able to help potential Hispanic applicants complete necessary application documents.

During FY 1992 and 1993, Hispanics comprised 5.4% of VA's total workforce, compared to governmentwide Hispanic employment of 5.6% in FY 1993. Although VA's percentage of Hispanic employees

remained unchanged, the actual number of Hispanic VA employees increased from 11,904 in 1992 to 12,263 in 1993.

Federal regulations require agencies, including VA, to notify state employment offices and Office of Personnel Management Federal Job Information Centers of opportunities which are open for consideration to non-status applicants. In addition, we promote these VA employment opportunities at professional conventions and job fairs where recruiters have direct contact with prospective applicants. We also maintain a mailing list of about 1,800 organizations or names, including recipients in the Hispanic community, to whom we mail the monthly VA Recruitment Bulletin. This Bulletin advertises nationwide hard-to-fill VA vacancies.

Question 4: For fiscal year 1993, VA reported the average grade for Hispanic employees was unchanged at 7.7. Describe the actions VA has taken to increase the average grade for Hispanic employees and increase the number of Hispanic employees in higher grade positions and assess the results of these actions.

Answer: As of September 26, 1994, the Department of Veterans Affairs had five Hispanics out of a total of 303 in the Senior Executive Service (SES), comprising 1.7% of VA's total SES employment. This compares to the June 30, 1994, governmentwide total of 130 Hispanics in the SES, or 1.8% of the total SES employment. The 1994 total also represents an increase of one Hispanic Senior Executive over 1993, and, of note, the employee is a career SES employee in Central Office. The other Central Office Hispanic Senior Executive is noncareer.

There are currently three SES Hispanic VA medical center Directors. There are five Hispanic VA medical center Associate Directors at the GS-14/15 grade levels, two of whom were promoted to this position since July 1993. Two Hispanics were among the 35 candidates selected to attend an assessment center for final screening for the Veterans Health Administration's (VHA) Associate Director/Health Care Management Training Program-1995.

VA administers numerous upward mobility and career field training programs designed to provide career advancement opportunities to higher graded positions. For example, in the past 7 years, eight Hispanic candidates have been selected for the VHA Associate Director/Health Care Management Training Program. Two Hispanic candidates have been selected as Human Resources Management Interns since 1992. Hispanic males in VHA professional occupations increased by 144 (11%) between 1990 and 1993. During the same period, the number of Hispanic females in professional occupations increased by 316 or 14%.

One of VA's newest initiatives is VHA's Minority Academic Institutions Research Training Program, a research grant program designed to provide opportunities to minorities, including Hispanics. The purpose of this research initiative is to promote and facilitate the pursuit of biomedical and behavioral research at minority academic institutions. The anticipated result is a greater number of minority faculty and students, including those at Hispanics-serving institutions, with the expertise and knowledges needed to compete for higher graded professional and technical positions.

During FY 1990-1994, VHA's Office of Health Care Staff Development and Retention (OHCSD&R) provided nearly \$62 million in educational assistance funding for VA employees and cooperative education students, an average of more than \$12 million per year. This permitted over 1,840 participants to pursue health care careers. A sizable number of minorities, including Hispanics and women who entered the program from low-paying, non professional positions, are reflected in this figure. It is noteworthy that many of these individuals would not have

been able to pursue their professional health care education without the program support provided by VA.

Another VHA initiative offers career entry opportunities at the high school level with career advancement potential. One hundred thousand dollars was awarded in FY 1994 to the San Antonio VA Medical Center to continue its cooperative health care education program with a local health careers magnet school. This high school co-op education program will enhance the representation of Hispanics in the Medical Center's workforce. The developmental program involves on-site experience in the VA Medical Center, which is coupled with classroom instruction that begins in high school and proceeds through the community college level. In some cases, participation in the program results in a bachelor's degree, thereby leading to eligibility for consideration for career-entry occupations with high grade level potential.

These examples of VA's efforts to increase the number of minorities, including Hispanics, in high grade positions illustrate the agency's commitment to total diversity at all grade levels. The agency will build on these efforts and will explore new initiatives to improve the advancement opportunities of Hispanics, as well as other minorities and women, into higher graded positions.

Question 5: Please describe in detail the new organizational structure Secretary Brown approved in September to support the Chief Minority Affairs Officer function.

Who are the members of the Chief Minority Affairs Officer steering committee? If not yet appointed, when are they expected to be appointed and when will the steering committee be operational?

How will this new structure, "ensure that the Chief Minority Affairs Officer function has adequate resources...."?

Answer: The new organizational structure approved by the Secretary will be two tiered. The first tier will be located at VACO and be comprised of key officials from the three administrations and the Office of Congressional Affairs, Office Of Human Resources and Administration, and General Counsel. These individuals will compose the steering committee which will serve as the Board of Directors for the Center for Minority Veterans (CMV) function. These individuals would set priorities for issues and activities that the CMV would undertake. They would also identify resources for approved projects and assign these from their respective organizations. We are in the process of designating the representatives from each office. The designation of representatives is to be completed and the steering committee to be operational by the end of this calendar year.

The second tier would be located at the field facility level. We anticipate each facility designating an individual as minority affairs liaison in a collateral duty capacity. If there is a significantly large minority veteran population served by that facility, then the facility Director will be encouraged to establish a full-time position. The individuals appointed to these positions would be (1) knowledgeable of VA programs and entitlements, (2) be capable of representing the facility in the community, (3) have good communications skills, (4) be able to contact policy and decision makers at the facility to initiate corrective actions and to identify problems or concerns, and (5) be sensitive to the needs and concerns of minority veteran group members. The minority affairs liaisons would function as the focal point for minority veteran's concerns at individual facilities. These individuals would conduct outreach to the minority veteran communities and provide information about VA programs, laws, regulations, and activities to minority veterans

through the use of local media, and participation in community group meetings and other local forums. They would encourage minority veterans and their dependents to utilize VA programs. They would also work with the local Veterans Service Organizations (VSOs) and community-based organizations to improve VA's image among minority veterans in the community. The local minority affairs liaisons would serve as the eyes and ears of the CMV reporting on VA initiatives, contacts, and problems.

We believe that this structure will provide access to resources necessary to conduct studies, surveys, focus groups, and minority group contacts. This structure would also ensure that the Administrations take responsibility for initiating localized programs that could be tailored to the specific needs and concerns of the minority populations in a particular service area. Finally, this structure will enable VACO to be aware of successful initiatives that could be duplicated at other facilities with similar populations and circumstances.

Question 6: VA is committed to, "improving minority and women veterans' access to VA health care and benefits programs tailored to meet their needs."

Please provide several examples of VA benefits programs tailored to meet the needs of Hispanic veterans.

Answer: VA has tailored some programs, such as the direct loan program to help Native American veterans purchase property on trust land and specialized health care services for women veterans, to meet the needs of specific veteran populations. Although we have not identified specific benefits programs that could be tailored to meet the needs of Hispanic veterans, we have made efforts to make VA benefits more accessible to Hispanic veterans and their families by addressing the language barrier. VA has a pamphlet, "Sus Beneficios", which provides information about VA benefits in Spanish. In addition, VA staff conduct benefits briefings for Hispanic Organizations and provide announcements to Spanish speaking radio stations. Many offices have bilingual counselors to assist clients during telephone and personal interviews and during hearings.

The information we receive from local minority affairs representatives will assist us in determining what changes might be appropriate with regard to VA benefits programs.

Question 7: Has VA conducted research and surveys to determine the specific needs and problems of Hispanic veterans and what were the results of this research? If not, should VA conduct such research?

Answer: The Office of Research and Development in the Veterans Health Administration is currently sponsoring three research projects and two research programs involving Hispanic veterans. Brief descriptions of these projects are provided in Attachment A.

In response to a recent request from Representatives Lane Evans and Maxine Waters, the Office of Research and Development provided a comprehensive list of research projects and programs that are directed towards the health problems of minorities and women. A copy of this list is provided in Attachment B.

ATTACHMENT A**Research Projects and Programs Involving Hispanic Veterans****Research Projects**

"Mexican-American Alzheimer's Victims and their Families: Development of a Psychoeducational Treatment Program" VAMC Palo Alto, CA

The purpose of this project is two-fold: 1) to modify existing psychoeducational materials (used successfully with Anglo caregivers) to make them culturally sensitive and relevant for Hispanic caregivers - that is, family members caring for an elder relative with Alzheimer's disease or a related type of illness, and 2) to interview families before and after the psychoeducational intervention to determine its effectiveness in reducing distress, such as depression, feelings of burden and anger, and increasing positive aspects of the situation, such as the extent of social support utilized.

"Phenytoin Michaelis-Menten Pharmacokinetics in Hispanic Men" VAMC San Juan, PR

The objectives of this study are to determine the disposition of the anti-seizure drug phenytoin in Hispanics. Effective and safe treatment of seizure disorders requires a precise understanding of the relationship between the administered dose of phenytoin and the systemic concentrations of the drug. These data will help reduce the risk of toxic phenytoin plasma levels when administering the drug to Hispanic patients.

"A Multicenter Pharmacy Based Study - Comparing the Efficacy of Zidovudine in Blacks, Hispanics and Whites" VAMC Sepulveda, CA

This project will examine the efficacy of Zidovudine, also known as AZT, a drug often used to treat AIDS. The study, which will utilize patient populations at multiple VA facilities, will attempt to discern differences in effectiveness across different ethnic groups.

Research Programs

"HSR&D Tucson Developmental Program" VAMC Tucson, AZ

Initial efforts will focus on developing a medical practice ethnic data base and a patient-level ethnicity data base. Through this research, investigators hope to be able to: 1) distinguish cultural issues from those arising out of different sources, 2) develop local measures that will refine ethnicity as a categorical value so as to make it more useful as both a research and clinical variable, and 3) identify those cultural and other social issues that contribute to the effectiveness or ineffectiveness of various treatments among the medical center's patient population.

"HSR&D Center for Hispanic Studies" VAMC Miami, FL and VAMC San Juan, PR

This center represents the first time funding has been awarded jointly to two VA medical centers to address the research needs of this specific ethnic population. Research topics include: pharmacological variables in treating Hispanics, rehabilitation of the frail elderly, health education and prevention, and relapse prevention of chronic psychiatric patients.

ATTACHMENT B

Minorities and Women in Research & Development

I. ETHNIC MINORITIES AND VA RESEARCH

Because the veteran population is comprised of a cross-section of America, VA research must recognize this diversity with a program that examines the unique health concerns of different racial and ethnic minorities. Many diseases are either unique to particular races and ethnic populations, occur with a higher prevalence within specific populations, or are most serious in specific groups. One example is hypertension, which has a high prevalence among Blacks.

Specific diseases that are particular problems among different racial and ethnic groups are not VA's sole concern, however. VA also is committed to examining potential variations in health care delivery and utilization that could be related to the ethnic or racial group of the VA patient.

The following is a list of selected research projects that address possible connections between racial and ethnic factors and either specific health conditions or the delivery and utilization of health care services. The research projects on this list are funded either centrally, through the Office of Research and Development, or through local funding mechanisms at individual medical centers. Projects funded through the Office of Research and Development are primarily funded by the Medical Research Service (MRS) or the Health Services Research and Development (HSR&D) Service. For centrally funded projects, the funding source is indicated in parentheses at the end of the entry.

Racial Differences

*Relationship of Race to Cardiovascular Procedure Use at VAMC's (Joseph Conigliario, M.D., M.P.H.; VAMC Pittsburgh, PA)
January 1995 - December 1996. (HSR&D)*

*Familial Patterns in Prostate Cancer (Glenn R. Cunningham, M.D. and Carol M. Ashton, M.D., M.P.H.; VAMC Houston, TX)
July 1993 - June 1998. (HSR&D)*

A Multicenter Pharmacy Based Study Comparing the Efficacy of Zidovudine in Blacks, Hispanics and Whites (Harriet Fine, Pharm D.; VAMC Sepulveda, CA) September 1993 - Present.

Ethnic Differences in Kinetics and Beta-Blockade (Francis Lam, Pharm.D.; VAMC San Antonio, TX) October 1, 1990 - Present.

Withdrawal of Life Support - Chart Review (Marta L. Render, M.D.; VAMC Cincinnati, OH) February 21, 1994 - Present.

Coping Mechanisms of Males with Ostomies (Nancy Schuller, R.N., B.S.N.; VAMC Chicago (WS), IL) November 1, 1993 - Present.

*Practice Pattern Research Unit: Practice Patterns and Variations in Care of VA Patients with Acute Myocardial Infarction (George Thibault, M.D. and Jennifer Daley, M.D.; VAMC West Roxbury, MA)
Planned: January 1995 - December 1998. (HSR&D)*

*Examining Racial Differences in Cardiac Care (Morris Weinberger, Ph.D.; VAMC Indianapolis, IN) October 1994 - March 1995. (HSR&D)
Gender and Race Differences*

*Estimating the Risk of Admission to VA Health Care Facilities (Elizabeth W. Bates, Ph.D.; VAMC Ann Arbor, MI)
July 1993 - June 1996. (HSR&D)*

Study of Quality of Care for Patients With AIDS-Related PCP
 (Charles Bennett, M.D; VAMC Durham, NC)
 September 1991 - September 1994. (HSR&D)

African-Americans

Compliance to a Low Fat Dietary Intervention Among African-American Men with Prostate Cancer (Harold Ballard, M.D.; VAMC New York, NY) Sept. 19, 1994 - Present.

Is Carotid Endarterectomy Under-Utilized in Black Patients?
 (Eugene Oddone, M.D., M.H.S. and Ronnie Horner, Ph.D.; VAMC Durham, NC) January 1995 - December 1996. (HSR&D)

The Validity & Reliability of the Black Elderly Alcohol Dependency Scale (BEADS) (Inez V. Joseph, R.N.; VAMC Tampa, FL) June 6, 1994 - Present.

Predicting the Compliance of African-American Men with Cocaine Abuse Treatment (Susan Mills, M.S., VAMC Philadelphia, PA) May 31, 1994 - Present.

Pilot Study to Evaluate Patient Interview Form for the Predictors of Hypertension-Related Renal Failure in Blacks (Mitchell Perry, Jr., M.D., VAMC St. Louis, MO) January 1, 1989 - February 4, 1994.

Do Staff Attitudes and Being in a Minority Role Affect the Female Patient in the Acute Psychiatric Setting of a Veterans Administration Medical Center? (Patricia F. Reed, B.S.N., VAMC Chillicothe, OH) April 1, 1991 - Present.

Screening Colonoscopy in Asymptomatic Blacks Between the Ages of 50-75 (Douglas K. Rex, M.D.; VAMC Indianapolis, IN) October 1, 1992 - Present.

Hispanic-Americans

Mexican-American Alzheimer's Victims and their Families: Development of a Psychoeducational Treatment Program (Dolores E. Gallagher-Thompson, Ph.D., VAMC Palo Alto, CA) January 1, 1991 - Present.

Phenytoin Michaelis-Menten Pharmacokinetics in Hispanic Men (Mitchell Nazario, Pharm D., VAMC San Juan, PR) May 1, 1992 - Present.

Native American

Providing Ethical Care for Navajo Patients in Western Hospitals (Joseph Carrese, M.D.; VAMC Seattle, WA) July 1993 - June 1994. (HSR&D)

Epidemiological, Clinical and Psychological Studies of Post-Traumatic Stress Disorder Among Selected Ethnocultural Minority Vietnam-era Veterans (Matthew Friedman Ph.D.; VAMC White River Junction, VT-- in collaboration with Mental Health And Behavioral Sciences Service) October 1991 - September 1995. (HSR&D)
Standardization of Lung Function for Healthy Non-Smoking Asian Indians (Ashok Fulambarker, M.D.; VAMC North Chicago, IL) March 1, 1993 - Present.

Analysis of Death of the Asian Indians in the USA Arvindkumar R. Shah, M.D., VAMC Reno, NV) June 1, 1992 - Present.

Asian-Americans

Race-related Stress and PTSD among Asian American Vietnam Veterans (Chalsa Loo, Ph.D.; VAMC Honolulu, HI)
Feb. 9, 1994 - Present.

A Study of the Health Care Experience of Elderly Filipino Veterans (Frank Stackhouse, M.D.; VAMC Seattle, WA)
January 1, 1994 - Present.

II. WOMEN AND VA RESEARCH

The presence of women in the military has never been so great; women comprise 11.6 percent of active duty forces and 13 percent of reserve forces. There are also currently more than 1.2 million women veterans. As the proportion of women in the VA population rises, the amount of research devoted to the special needs of female veterans must increase as well.

VA research is committed to integrating the health concerns of female veterans with its investigator initiated research program. Consistent with NIH criteria for identifying women's health issues, the Office of Research and Development funds research projects addressing diseases or conditions unique to women or some subgroup of women, more prevalent in women, most serious among women, or diseases or conditions for which risk factors and interventions differ for men and women. Examples of conditions which are encompassed in these categories include breast and ovarian cancer, osteoporosis, and gall bladder disease.

In addition to research directed specifically at women's health issues, several VA studies are examining the possible role gender differences may play in both specific health conditions and as possible factors in the utilization and delivery of health care. The following is a listing of selected current projects in women's health and gender-comparative studies. As noted in the first section, projects on this list may be funded either centrally by the Office of Research and Development or through local channels at individual medical centers.

Women's Health

SWOG 8851 Phase III Comparison of Combination of Chemotherapy and Chemohormonal Therapy in Premenopausal Women with Breast Cancer (Kathy Albain, M.D.; VAMC Hines, IL) February 1, 1992 - Present.

Interacting of TGF-alpha and TGF-beta with Human Breast Cancer Cells (Carlos L. Arteaga, M.D.; VAMC Nashville, TN) October 1, 1988 - Present. (MRS)

Paracine Interactions Between Human Breast Cancer Cells & Fibroblasts (Carlos Arteaga, M.D.; VAMC Nashville, TN) June 1, 1989 - Present.

Breast Cancer Chemoprevention Trial NSAB P-1 (Rosemary Carroll, M.D.; VAMC Chicago (West Side), IL) March 1, 1992 - Present.

Reproductive Health in Women Veterans Related to Military Experience and Post-traumatic Stress Disorder (Deborah DelJunco, Ph.D.; VAMC Houston, TX HSR&D Field Program) April 1995 - September 1997. (HSR&D)

Breast Cancer Among Women Veterans -- Pilot/Feasibility Study (John R. Feussner, MD and Denise M. Hynes, RN, Ph.D.; HSR&D Field Programs, VAMC Durham, NC & VAMC Hines, IL) October 1993 - March 1995. (HSR&D)

Retinoid Modulation of IGF-Binding in Breast Cancer (Joseph A. Fontana, M.D., Ph.D.; VAMC Baltimore, MD) April 1, 1988 - Present. (MRS)

Labor Force Participation, Health Insurance Coverage and Health Care Use of Women Veterans (Kathleen Gillespie, Ph.D.; VAMC St. Louis, MO -- Ann Arbor, MI HSR&D Program) October 1994 - March 1996. (HSR&D)

Mammography: Beliefs, Attitudes and Values of Women Ages 40-49 (Maryann C. Gilligan, M.D.; VAMC Seattle, WA) February 1993 - April 1994. (HSR&D)

Role of Gonococcal Pili, PI, PIII in Invasion of Genital Epithelium (Gary L. Gorby, M.D.; VAMC Omaha, NE) May 1, 1993 - Present. (MRS)

Effects of Estrogen Administration on Peripheral Mononuclear Cell Function in Post-Menopausal Women (Theodore J. Hahn, M.D.; VAMC West Los Angeles (Wadsworth), CA) April 1, 1987 - Present.

A Study of Reproductive Outcomes Among Women Vietnam Veterans (Han K. Kang, Dr. P.H.; VAMC Washington, D.C.) March 1, 1992 - Present. (MRS)

Colo-Rectal and Breast Cancer: Cell Kinetics by in Vivo DNA Labeling (Seema Khan, M.D.; VAMC Syracuse, NY) May 1, 1993 - Present.

Use of LH-RH Analogs in Breast and Ovarian Cancer (Andrew V. Schally, Ph.D.; VAMC New Orleans, LA) November 1, 1991 - Present. (MRS)

Quality of Life in Women Veterans Using VA Ambulatory Health Care (Katherine Skinner, Ph.D. and Lewis Kazis, ScD; VAMC Bedford, NH HSR&D Field Program) October 1994 - March 1997. (HSR&D)

Teratogenic Effects of Alcoholism (Ann K. Snyder, Ph.D.; VAMC North Chicago, IL) July 1, 1989 - Present. (MRS)

The Incidence of Post-traumatic Stress Disorder (PTSD) in Abused Women (Charles G. Watson, Ph.D.; VAMC St. Cloud, MN) November 1, 1990 - Present. (MRS)

Developing a Long-term Care Utilization Database for Women Veterans (Frances Weaver, Ph.D. and Marylou Guihan Ph.D.; VAMC Hines, IL HSR&D Field Program) October 1994 - March 1996. (HSR&D)

Effects of the Menstrual Cycle on the ECG (Elizabeth H. Weinshel, M.D.; VAMC New York, NY) November 1, 1991 - Present.

The Evaluation of Comprehensive Women Veterans Health Centers and of Full-time Women Veteran Coordinators (Thomas Weiss, Ph.D.; VAMC Houston, TX HSR&D Field Program) August 1993 - September 1995. (HSR&D)

Mental Health Needs of Female Veterans (Janet K. Willer, Ph.D.; VAMC Chicago (West Side), IL) January 1, 1993 - Present.

Female Veterans Perceptions and Experiences in Accessing VHA Care (Jessica Wolfe, Ph.D. and Jennifer Daley, MD VAMC Boston and VAMC West Roxbury) January 1995 - June 1997. (HSR&D)

Influence of Diet on Mammographic Parenchymal Pattern (Donald K. Wood, M.D.; VAMC Chicago (West Side), IL) September 1, 1992 - Present.

Gender Differences

Gender Differences in Facial Affect Perception (Charles E. Drebring, Ph.D.; VAMC Bedford, MA) April 15, 1994 - Present.

Familial Drinking History, Gender, Family Environment as Predictors of Alcohol Use Patterns and Psychological Adjustment among College Students (Wallace Joslyn, Ph.D.; VAMC Knoxville, IA) November 1, 1993 - Present.

Aging, Gender and Alfentanil Pharmacokinetics (Evan D. Kharasch, M.D., Ph.D.; VAMC Seattle, WA) May 1, 1993 - Present.

Aging, Gender and Mechanisms of Altered Opioid Disposition (Evan D. Kharasch, M.D., Ph.D.; VAMC Seattle, WA) April 1, 1994 - Present. (MRS)

Gender, Eicosanoid and Immunity (Crystal A. Leslie, Ph.D., M.P.H.; VAMC Bedford, MA) April 1, 1992 - Present. (MRS)

Gender-Specific Outpatients Health Services at a VAMC: Awareness and Utilization Levels Among Women Veterans (Daniel F. Sullivan; VAMC Providence, RI) March 23, 1994 - Present.

Alcohol Regulation of Neuroendocrine-Immune Interactions In Vivo (Anna N. Taylor, Ph.D.; VAMC West Los Angeles (Brentwood), CA) November 1, 1990 - Present. (MRS)

III. SPECIAL PROGRAMS INVOLVING ETHNIC MINORITIES AND WOMEN

In addition to supporting research in issues concerning minorities, the VA supports a variety of special programs designed to increase the role of minority researchers in research.

In 1994, VA Medical Research instituted a Research Training Initiative for Historically Black Colleges and Universities and Hispanic-Serving Institutions. The program is designed to increase the number of VA researchers from historically underrepresented minority groups, and to support research and research training which will enhance collaboration between VA researchers and scientists affiliated with historically Black colleges and universities and Hispanic-serving institutions.

Health Services Research and Development's (HSR&D) Developmental Program promotes the development of health services research capacity at the local VA medical center level. Each Developmental Program generates its own research agenda, primarily focused on health care delivery issues. The Developmental Programs focusing on issues related to minority populations are listed below. The percentage of female principal investigators for Developmental Program Projects is 53.8 percent for FY 1994.

Ethnic-specific outcomes research among Native American and Hispanic veterans. (Murray A. Katz, M.D.; VAMC Tucson, AZ) October 1994 -September 1996.

HSR&D Center for Hispanic Studies. (Carole Devito, Ph.D.; VAMC Miami, FL and Jaime Alvelo, DSW; VAMC San Juan, PR) June 1992 - September 1995.

Enhancing Health Care Services for African Americans, Native Americans and women. (Marie Bernard, MD; VAMC Oklahoma City, OK) October 1993 - September 1995.

Under the sponsorship of the Medical Care section of the American Public Health Association (APHA), VA HSR&D researchers will be conducting a special session on chronic disease in Mexican Americans at the APHA annual meeting in Washington, DC on November 2, 1994. The session entitled, "Chronic Disease, Function, Treatment Outcomes, and Survival in Mexican Americans and Non-Hispanic Whites. Observations from the Operating Room, the Nursing Home and the Dialysis Unit" will include the following presentations:

Ethnic Differences in Incidence of and Survival from Diabetic End Stage Renal Disease: What Can We Learn? (J. Pugh, M.D.).

Function and Cognition in Mexican American and Non-Hispanic White Nursing Home Residents: How Do They Differ? (L. Chido, M.D.).

Elders and Surgery: The Utility of Indices of Disease, Cardiovascular and Pulmonary Risk in Predicting Surgical Outcome (V. Lawrence, M.D.).

Frail Long-stay Nursing Home Residents: Effects of Comorbid Disease, Depression and Cognition on Treatment Outcome and Survival (M. Gerety, M.D.).

In Fiscal Year 1994, the Health Services Research and Development Service implemented a special Service Directed initiative on women's health. These studies should demonstrate ways to increase services to women, to alter the quality of and access to care, and document the economic impact of providing care for women's veterans.

In 1991, The Department of Veterans Affairs issued a directive that all research involving human subjects conducted with VA funding include female veterans, unless a compelling case can be offered otherwise. This action preceded a similar policy statement issued by the National Institutes of Health, and is adhered to by the VA Office of Research and Development.

The Office of Research and Development also is committed to increasing the role of minorities and women in the peer review process which is a part of all investigator-initiated research funded by the Office of Research and Development. For example, the percentage of women on the Health Service Research and Development (HSR&D) Scientific Review and Evaluation Board will increase from 25 percent to 33 percent between 1994 and 1995.

The VA Health Services Research and Development Service has nine Field Program Centers of Excellence located at VA medical centers throughout the nation. Of these nine programs, three are directed by women (2 MD, 1 Ph.D.). Of the 125 core staff in these programs, 56 percent are female. Of the female core staff, 71.4% have advanced degrees with 62.7 percent of these degrees being at the doctoral level (Ph.D. or M.D.). Additionally, the Deputy Director of the HSR&D Service is a woman who holds both a Ph.D. and an M.B.A. Of the three Service level program managers, one is a woman who holds a J.D. and two masters degrees. Overall, in FY 1995, women are the principal investigators of 29 percent of 124 research projects funded by HSR&D under its seven program areas. The percentage of female principal investigators for VA HSR&D Service Directed Research and Investigator-Initiated Research is 28.9 percent in FY 1994 and 28.4 percent in FY 1995.

In order to promote women in VA Medical Research, the Task Force on Women Scientists in VA Medical Research was established. This task force, consisting of VA-funded women scientists, held an initial meeting October 4, 1994, in Boston, MA. Several initiatives were proposed designed to encourage young women to pursue research careers at VA facilities. Additionally, to facilitate equal representation at higher managerial and professional levels, the VA Health Services Research and Development Service sponsors a program of post-doctoral research training that is available equally to men and women. In 1994 there were 28 post-doctoral trainees, over half (53.6 percent) of whom were women.

VA's Northeast Program Evaluation Center (NEPEC) at VAMC West Haven has conducted a study that identified utilization rates of minority veterans in VA's specially funded PTSD Clinical Teams (PCTs) outpatient programs (see attachment). The study found that Hispanic veterans use these outpatient PTSD treatment services at rates similar to white, non-hispanic veterans. Within the hispanic veteran population, veterans of Mexican descent use VA PTSD outpatient services at a lower rate than veterans of Puerto Rican descent. In general, we consider this to be a positive finding and one that would suggest that Hispanic veterans see VA as being able to meet their PTSD treatment needs. In contrast, a review of the literature indicates that Hispanics generally use private and other public sector mental health services in the community at lower rates than white, non-Hispanic citizens.

In addition to the study conducted by NEPEC, VA's National Center for PTSD was given a legislative mandate to conduct an epidemiological study on the prevalence of PTSD among Native American veterans, Hawaiian veterans and other Pacific Island veterans. This study, known as the Matsunaga Study, is scheduled

for completion in mid-FY 1995. The National Center for PTSD plans to use the methodology and resources that were developed for the Matsunaga Study to study similar issues concerning African American and Hispanic veterans with PTSD.

The National Vietnam Veterans Readjustment Study (NVVS) conducted by the Research Triangle Institute (RTI), on contract with VA, has produced scientific epidemiological data indicating that the prevalence rate of diagnosable post-traumatic stress disorder (PTSD) in Vietnam veterans is 15.2 percent or approximately 480,000 current cases; an additional 11 percent, or 341,000 veterans, have some symptoms of PTSD but not the full amount required for diagnosis. Broken out by ethnic groups the prevalence of PTSD is 20.6 percent for African American, 27.9 percent for Hispanic and 13.7 percent for white Vietnam theater veterans. Rates of various social, family and economic problems are also correspondingly higher for minority veterans. In addition, 50 percent of all Vietnam theater veterans with PTSD were diagnosed to have other psychiatric disorders such as depression, substance abuse or anxiety disorders. Continued emphasis on the outreach component of the Vet Center mission has been instrumental in finding, contacting and bringing many Vietnam veterans to available services at Vet Centers and other VA and non-VA facilities. Vet Center counselors have provided definitive services for many veterans (especially for the 50 percent without other psychiatric disorders), while others with more severe PTSD or other psychiatric problems are referred to VA medical center based programs such as the PTSD Clinical Teams.

With particular reference to male Hispanic Vietnam theater veterans, they represented over five percent (or approximately 175,000) of the 3.14 million men who served in the southeast Asian theater of war. At a prevalence rate for PTSD of 27.9 percent, this projects inferentially to approximately 48,000 Hispanic veterans with current PTSD, as of 1988.

Readjustment Counseling Service, in collaboration with VA's National Center for PTSD, conducted a prospective study on a sample of Persian Gulf veteran new cases being seen at 82 Vet Centers. This study will produce valuable data for assessing, in the years ahead, the impact of wartime duty on readjustment and other aspects of psychological functioning. This is the first prospective study on war veterans' readjustment carried out by VA in its history.

In the initial phase (from October 15, 1991 to April 15, 1992), the Persian Gulf veteran survey was disseminated through 82 Vet Centers nationwide, from Hawaii to Alaska to Puerto Rico. The overall PTSD prevalence for this sample was 11.5 percent. The PTSD prevalence in a sub-group seeking specifically help for psychological distress was 37.1 percent. The six-month follow-up study was carried out from April 15 to October 15, 1992, at which time the participating Vet Centers mailed the follow-up surveys to all veterans who participated in the initial phase. The overall prevalence of PTSD for the 16 month follow-up group was 14 percent. However, with particular reference to the group of veterans specifically seeking help for psychological distress, the level of PTSD at the six month interval was markedly reduced (9.4 percent compared to 37.1 percent). The 18 month and final follow-up survey was completed late in 1993, and the final results will be reported in the near future. Although we understand from 15 years of program experience that enhanced levels of community outreach and intervention are needed to locate and engage Hispanic and other minority veterans, the data to be reported upon completion of all three phases of the study will contain additional useful information regarding PTSD and its treatment in minority Persian Gulf veterans.

Question 8: Is improving access to minority veterans a factor in selecting the site for a VA facility?

In order of their priority, please identify the factors used by VA when selecting the site for a VA facility?

Answer: The information required for ranking purposes used by VA when selecting the site for a new VA outpatient clinic, in priority order, is as follows:

1. Projected number of outpatient visits
2. Number of veterans living in Health Manpower Shortage Areas (HMSA) with Distributed Population Planning Base (DPPB)
3. Distance (miles) from a VA facility
4. Percentage of veterans with service-connected disabilities
5. Percentage of population below poverty level

QUESTIONS SUBMITTED BY
HONORABLE LANE EVANS, CHAIRMAN
SUBCOMMITTEE ON OVERSIGHT & INVESTIGATIONS
COMMITTEE ON VETERAN'S AFFAIRS

HISPANIC VETERANS: CONTRIBUTIONS TO THE NATION AND COMMUNITY,
RECEIPT OF FEDERAL VETERANS BENEFITS AND RELATED ISSUES

* SEPTEMBER 28, 1994

QUESTIONS FOR JOSE R. CORONADO, DIRECTOR
AUDIE L. MURPHY MEMORIAL VETERANS HOSPITAL
SAN ANTONIO, TEXAS

Question 1: How have VA clinics served veterans' families as noted on the fourth page of your statement?

Answer: Current regulations prevent the Veterans Health Administration from providing direct patient care to a veteran's family, however the family does benefit from collateral visits. These collateral visits are provided primarily by the health care professionals in psychology, psychiatry, social work, and dietetics. For instance, a social worker will assist in the establishment of periodic day care for an elderly veteran to provide a respite for the veteran's family. This respite enables members of the family to hold jobs they may not have otherwise been able to hold, or to do the weekly shopping and run errands. Another example of a collateral visit is a dietitian making an in-home visit to provide nutritional counseling for a home bound Hispanic veteran with diabetes. The dietitian is treating the veteran, but the other members of the family will also benefit in terms of an improved diet. Therefore, although the hospital and the clinics do not directly treat a veteran's family, the family does receive secondary benefit in the form of an improve home and social environment.

Question 2: What has the Mexican American Medical Effectiveness Research Center learned about the health care needs of Hispanics and how has this information been put to use throughout VA?

Answer: The Mexican American Medical Treatment Effectiveness Research Center (MERECE) is funded by the Agency for Health Care Policy and Research to study chronic disabling conditions among the Mexican American population. Findings to date include:

1. Diabetes is a leading cause of mortality and morbidity (end stage renal disease, amputations) among Hispanics, particularly Mexican Americans.
2. Depression is a common disorder.
3. Hispanics in nursing homes are different from non-Hispanic Whites and may have different health care needs:
 - a. Hispanic nursing home residents are younger, more often males, have 1/3 the number of years education, more often on Medicaid, more dependent in activities of daily living, and have higher prevalence of hypertension, ischemic heart disease, stroke, diabetes, and anemia than non-Hispanic Whites;
 - b. Hispanics are equally likely to be vision impaired but less likely to have glasses than non-Hispanic Whites;
 - c. Hispanics are more likely to be hearing impaired but have 1/3 the number of hearing aids as non-Hispanic Whites;
 - d. More Hispanics in nursing homes are unable to respond sensibly to mental status questions and those that can respond have poorer mental status; however, Hispanics are not more likely

to report depressive symptoms nor are they less likely to be diagnosed as depressed than non-Hispanic Whites;

e. Hispanics are more likely to self-report poorer health status than non-Hispanic Whites.

4. The English and Spanish versions of the Folstein Mini-Mental State Exam (MMSE), a commonly used test for diagnosis of dementia, may perform satisfactorily for population studies which involve comparisons on MMSE scores, but the language versions vary considerably in terms of individual diagnoses; these findings suggest a need to develop a new cross-cultural mental status exam that involves minimal reliance on literacy skills and is appropriately translated to avoid ambiguity.

5. The English and Spanish versions of the McGill Pain Questionnaire are equivalent semantically and findings suggest each perform equally well.

6. Hispanics have higher rates of diabetic and hypertensive end-stage renal disease than non-Hispanic Whites but survive longer on hemodialysis. Hispanics are less likely to receive renal transplants.

The impact of MERECE findings on VA services include:

1. Increases in services to diabetic patients to meet the increased needs of Hispanics including photographic screening services for diabetic retinopathy, multidisciplinary clinics to prevent amputations, and achieving American Diabetes Association recognition for the diabetes education program.

2. Recognition of the need for increased staffing in nursing homes with predominately Hispanic patients.

3. Recognition of the need to use culturally appropriate screening tests for dementia and depression.

**ETHNOCULTURAL AND RACIAL
FACTORS IN THE TREATMENT OF
WAR-RELATED POSTTRAUMATIC
STRESS DISORDER**



**Department of
Veterans Affairs**

NORTHEAST PROGRAM EVALUATION CENTER
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**Ethnocultural and Racial Factors in the Treatment
of War-Related Posttraumatic Stress Disorder**

by

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April 29, 1994

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Executive Summary

This report presents four studies of the role of ethnocultural and racial factors in the treatment of Posttraumatic Stress Disorder at Department of Veterans Affairs (VA) medical centers. Data for these studies were obtained from a national survey of Vietnam Era veterans, the National Vietnam Veterans Readjustment Study (NVVRS), and from the national evaluation of the VA PTSD Clinical Teams (PCT) Program. These studies support the following conclusions:

1. There are important differences between ethnocultural groups in socio-demographic characteristics, clinical needs and community adjustment.
2. There is no evidence that veterans who are members of ethnocultural minority groups avoid using VA services. Black veterans and Puerto Rican hispanic veterans were more likely than whites to use general VA health care services, and blacks were more likely than whites to use VA inpatient mental health services. Black veterans and Mexican hispanic veterans were significantly less likely than white veterans to use non-VA mental health services or self-help groups.
3. In a study of almost 5,000 veterans treated in VA's PCT program, blacks reported a greater need than whites for help with financial support, employment, and alcohol and drug abuse. Consistent with their expressed needs, they made greater use of substance abuse services, but less use of psychiatric services or psychotropic medication. Greater symptomatology and use of abreactive therapies was observed among hispanics, especially Puerto Rican hispanics, and is consistent with other epidemiologic studies of their patterns of service use. When the influence of the race of the treating clinician is statistically controlled, black veterans use fewer PCT services than white veterans, but are rated by their clinicians as showing no less improvement than white veterans.
4. A study of veteran-clinician racial pairing, however, suggests that the pairing of white clinicians with black veterans is, associated with lower program participation and lower clinician-rated improvement. On several measures, nonetheless, black veterans showed less participation than whites when treated by either white or black clinicians.
5. An outcome study of a subgroup of 525 veterans found that when outcome is rigorously measured using standardized psychometric instruments, blacks and whites experience similar degrees of improvement and express similar levels of satisfaction with services. Because only one black clinician was involved in this study, the issue of racial

matching could not be addressed. In addition, in this subsample, in contrast to the larger sample, blacks and whites received services at similar levels of intensity.

6. Although these studies suggest that black veterans may use fewer services and may show less improvement than white veterans when treated by white clinicians, they are not conclusive because in the smaller, more rigorously studied sample, there were no racial differences in use of services, and too few black clinicians to assess the impact of veteran-clinician pairing.
7. Even though these analyses are only suggestive of poorer outcomes when black veterans are treated by white clinicians, they consistently show less service use by black veterans when treated by white clinicians. In view of these findings, several courses of action may be in order. One step that would increase the ethnocultural and racial sensitivity of available services is to hire additional minority clinicians. In addition, experiential training activities for clinicians, and modules addressing distinctive clinical needs of minority veterans deserve consideration.

The studies presented here represent a substantial advance in our knowledge of the importance of the role of ethnocultural and racial factors in the treatment of PTSD. They, nevertheless, leave many questions unanswered, and more importantly, many problems unsolved. Open discussion of differences between people can be difficult. In a society in which ethnocultural and racial diversity is steadily increasing, the development of such a dialogue must be placed high on the national and VA agendas.

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The impetus for the work presented here came, to a significant extent, from an international conference sponsored jointly by the National Center for PTSD and the NIMH in Honolulu, Hawaii, in the summer of 1993. We would especially like to thank Anthony Marsella PhD, Matthew Friedman MD PhD and Ray Scurfield DSW who organized the conference, as well as the other conference participants, for their encouragement, support and counsel.

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Chapter 1 - Introduction

by

Robert Rosenheck MD and Alan Fontana PhD

I. Background

Three years ago, on a Wednesday night in early March, virtually every television set in America was illuminated with the image of a group of white policemen beating a black man as he lay immobilized on the pavement of a Los Angeles street. About a year later, the most destructive urban riot in recent times erupted in South Central Los Angeles when a jury found those policemen not guilty of any assault charges. Together these events abruptly reminded Americans that over 30 years after the flowering of the modern civil rights movement, and over 130 years after the conclusion of the Civil War, race relations in America remained troubled.

In the years since the beating of Rodney King, there has been increased public discussion of the growing ethnocultural diversity of our country. Medical researchers, too, have paid increasing attention to the health status and treatment of minorities in our health care system. Although gaps in mortality rates and in the use of health care services have narrowed during this century, studies have consistently shown that black Americans and members of other racial and ethnocultural groups suffer more health problems than whites (1), and have reduced access to health care services (2). In the past six months, for example, the New England Journal of Medicine published one study showing that among AIDS patients, blacks are less likely to get special medications than whites (3), and another, by VA researchers, showing that among veterans treated at VA medical centers, black men are less likely than white men to undergo major coronary artery procedures (4). Racial disparities are still found in health care, as they are found in other aspects of American life.

II. Specialized VA Programs for Underserved Veterans

Beginning in 1987, the Veterans Health Administration (VHA) of the Department of Veterans Affairs initiated a series of new programs to serve underserved veterans with special mental health treatment needs. These programs were specifically designed to provide specialized assistance to homeless veterans; to veterans suffering from substance abuse disorders; and especially, to veterans suffering from Posttraumatic Stress Disorder (PTSD) related to their military experience. A unique feature of the implementation of these initiatives, initiated under the auspices of VHA's Mental Health and Behavioral Sciences Service, was that each of them was the object of systematic program evaluation and performance monitoring.

"Health care accountability" have become watchwords of our times. As more and more of health care is funded through public expenditures, it becomes increasingly incumbent on providers to test the effectiveness and efficiency of their programs, to be sure that they are doing the job that they were intended to do, and to

ensure that they are obtaining the best results possible at appropriate cost.

Since 1987, VA's Northeast Program Evaluation Center, which is also the Evaluation Division of the National Center for PTSD, located at the VA medical center in West Haven, CT, has been evaluating and monitoring specialized VA programs for homeless veterans (5) and for veterans suffering from PTSD (6-8). These evaluations have examined the structure, process and outcome of these programs as addressed by four core questions.

- 1) Are program resources being used to establish the programs as originally conceived?
- 2) Are programs treating the intended target population?
- 3) Are the programs delivering appropriate services?
- 4) Is program participation associated with clinical improvement?

III. Expanding the Scope of Program Evaluation

The special challenge posed to mental health treatment programs by ethnocultural diversity has long been a subject of interest and concern (9-10). It is widely recognized that fundamental ethnocultural differences often exist between different groups of patients as well as between clinicians and patients. These differences, whether in language, cultural values, world-view, or expressive style, can present formidable barriers to the development of optimal helping relationships. One of the basic objectives of the community mental health movement of the early 1960s was to assure that accessible, effective, and culturally sensitive mental health services were available to all segments of the population. It is generally recognized that this objective has not been completely achieved.

In view of these considerations, the Northeast Program Evaluation Center has recently extended its approach to evaluating specialized VA mental health programs to include assessment of the relationship between ethnocultural group membership and various aspects of service delivery. This report presents four papers that address ethnocultural and/or racial aspects of specialized outpatient treatment for PTSD. It is especially appropriate that we have focused this first series of evaluation studies on PTSD, for three reasons:

First, PTSD is the only psychiatric disorder that is specifically and directly related to the stresses of military service. It therefore has a special and central importance in the VA mission "to bind the wounds of war."

Second, a major study of PTSD among Vietnam veterans has shown that rates of PTSD among black and hispanic veterans are significantly greater than among white veterans: 20.6% among blacks and 27.9% among hispanics, as compared to 13.7% among whites (11).

Third, these studies represent an important response to the charge to the National Center for PTSD, set forth in Public Law 101-144, to carry out research, educational and consultative activities concerning ethnic minority Vietnam veterans.

In these papers, we consider six distinct but related questions.

1. Are there differences between ethnocultural subgroups of veterans in their assessed needs, i.e., in their clinical problems or community adjustment?
2. Are there differences between ethnocultural subgroups of veterans in their lifetime use of mental health services, and, more specifically, in their use of VA services? This question concerns whether veterans have ever used any services from various providers, and thus addresses the issue of basic access.
3. Are there differences between ethnocultural subgroups of veterans in the types of VA services they have received, or in the intensity of services they have received?
4. Does pairing of veterans with clinicians of the same or different race have an impact on either use of services or improvement?
5. Are there different responses to treatment between racial groups when responses are assessed using either clinician improvement ratings or standardized psychometric instruments ?
6. Do the answers to the above questions suggest a need for additional clinical, administrative, or educational initiatives to improve the services provided to minority group veterans?

Two very different types of study samples are needed to address these questions. The first two questions, concerning differences in current service needs and lifetime service use in the general population of U.S. veterans, require information on a representative community sample of veterans. The principal source of information used to address these questions (see Chapter 2) comes from the national sample of veterans who participated in the National Vietnam Veterans Readjustment Study (NVVRS) (11).

The next three questions concern differences between subgroups of veterans who have received treatment. Responses to these questions require data on the process and outcome of clinical samples of veterans who have sought treatment. Data on such veterans are presented from NEPEC's multi-phase national evaluation of VA's PTSD Clinical Teams Program (6-8).

IV. Summary of Findings

Use of services in a community sample. The first study involves comparison of service use by five ethnocultural groups: whites, blacks, Puerto Rican hispanics, Mexican hispanics and others. Significant differences are noted between the groups on numerous socio-demographic, economic and clinical characteristics, with whites being healthier and better off financially than other groups.

When no adjustment is made for these characteristics, there are no significant differences between the groups on the use of mental health services provided by mental health professionals, non-psychiatrist physicians, clergy, or self-help groups. Whites are more likely than other groups, however, to have used formal mental health services from non-VA providers, but whites are less likely than blacks and Puerto Rican hispanics to have used general VA health care services.

After adjusting for differences in need and economic factors, black veterans and Puerto Rican hispanic veterans are more likely than whites to have used general VA health care services, and blacks are more likely to have used VA inpatient mental health services. There are no differences between ethnocultural groups in their use of outpatient VA mental health services. In contrast, black veterans and Mexican hispanic veterans are significantly less likely than white veterans to have used non-VA mental health services or self-help groups.

This study suggests that although military service during the Vietnam conflict may have alienated many minority veterans from the Federal government, their reluctance to use mental health services does not extend to the VA system, and some minority groups are actually more likely than whites to choose VA services.

Use of services in a VA clinical sample. In the second study, utilizing a national sample of almost 5,000 veterans seeking treatment from VA's PTSD Clinical Teams (PCT) program, blacks were more likely than whites to express a wish for help with financial support, employment, and alcohol and drug abuse. Consistent with these expressed needs, they made greater use of substance abuse services, but less use of psychiatric services. Greater symptomatology and use of abreactive therapies were observed among hispanics, especially Puerto Rican hispanics. While there was only

a small number of significant differences between groups in receipt of PCT services, blacks received less treatment than whites on several measures: they participated in treatment for shorter periods of time, were more likely to terminate early, and had fewer treatment sessions. They also were rated by their clinicians as showing less improvement than whites on 3 of 16 improvement measures. Since this study took no account of the race or other characteristics of the treating clinician, a third study was conducted using additional information that was obtained from the sites on the race, gender and veteran status of the clinicians who provided the treatment.

Veteran-clinician matching, service delivery and outcome. When the race, gender, veteran status and professional discipline of the clinicians were statistically controlled, blacks still showed less participation in treatment on several measures, but no differences were observed on clinician-rated improvement.

These findings did not address the possibility, however, that veteran-clinician racial pairing might have important effects on treatment participation and improvement. Further analyses compared treatment involving white clinicians and black veterans with treatment involving other clinician-veteran racial combinations. In these analyses, the specific pairing of white clinicians with black veterans was associated with lower program participation (6 of 24 measures), and with lower clinician-rated improvement (5 of 16 measures), than the pairing of either black clinicians and black veterans or white clinicians and white veterans. Aside from racial pairing, however, when treated by either black or white clinicians, black veterans had poorer attendance than white veterans, were rated by their clinicians as being less committed to treatment, received more treatment for substance abuse and were less likely to be prescribed antidepressant medications.

This study shows that the pairing of black veterans with white clinicians is associated with reduced participation and lower improvement ratings on some, but not all, measures. On some measures of participation, black veterans received less intensive services regardless of the race of the clinician.

Psychometrically measured treatment outcome. The fourth study examined the relationship between racial group membership and psychometrically measured outcomes for 525 veterans who were assessed 4, 8 and 12 months after entry into the PCT program. In this sample, there were no significant differences between blacks and whites on any of the clinicians' improvement ratings, or on 13 of the 17 psychometric outcome measures. During the first 4 months of treatment, however, white veterans showed more improvement than blacks on psychiatric symptoms, while blacks showed more improvement in days worked and satisfaction with services. During the following eight months, blacks showed more improvement than whites on psychological distress but also a relative decline in

days worked. In this prospective study, therefore, no consistent or sustained differences were observed between racial groups in improvement, whether measured as psychometric change or as clinicians' ratings. Because only one black clinician was involved in this study, the impact of white-black racial pairing could not be evaluated.

V. Conclusions

It is evident in the detailed research reports presented in the next four chapters that the studies presented here are neither definitive, nor conclusive. They do, however, suggest the following:

1. There are important differences between ethnocultural groups in socio-demographic characteristics, clinical needs and community adjustment.
2. There is no evidence that veterans who are members of ethnocultural minority groups avoid using VA services.
3. Among veterans treated in VA's PCT program, blacks reported a greater need than whites for help with financial support, employment, and alcohol and drug abuse. Greater symptomatology and use of abreactive therapies was observed among hispanics, especially Puerto Rican hispanics. When consideration is given to the race of the treating clinician, black veterans use fewer services, but to be rated by their clinicians as showing no less improvement than whites.
4. The specific pairing of white clinicians with black veterans is, associated with lower program participation and lower clinician-rated improvement. On several measures, however, black veterans showed less participation than whites when treated by either white or black clinicians.
5. An outcome study of a subgroup of 525 veterans found that blacks and whites experience similar degrees of improvement and express similar levels of satisfaction with services.
6. Although these studies suggest that black veterans may use fewer services and may show less improvement than white veterans when treated by white clinicians, they are not conclusive because in the smaller, more rigorously studied sample, there were no racial differences in use of services, and there was an inadequate sample of black clinicians to assess the impact of racial pairing.
7. Even though the analyses are only suggestive of poorer outcomes when black veterans are treated by white clinicians, they consistently show less service use by

black veterans when treated by white clinicians. In view of these findings, several courses of action may be in order. One step that would increase the ethno-cultural and racial sensitivity of available services is to hire additional minority clinicians. In addition, experiential training activities for clinicians, and modules addressing distinctive clinical needs of minority veterans deserve consideration.

While the studies presented here represent a substantial advance in our knowledge of the operation of racial and ethnocultural factors in the treatment of PTSD, they leave many questions unanswered, and more importantly, many problems unsolved. Open discussion of differences between people can be difficult. In a society in which ethnocultural and racial diversity is steadily increasing, the development of such a dialogue must be placed high on the national and VA agendas.

References

1. Williams DR, Lavizzo-Mourne R and Rueben W (1994) The concept of race and health status in America, *Publ Hlth Reports* 109: 26-41.
2. Blendon RJ, Aiken LH, Freeman HE and Corey CR (1989) Access to Medical Care for Black and White Americans, *JAMA* 261:278-281.
3. Moore RD, Stanton D, Gopalan R and Chaisson RE (1994) Racial differences in the use of drug therapy for HIV disease in an urban community. *New England Journal of Medicine* 330: 763-768.
4. Whittle J, Conigliaro J, Good CB and Lofgren RP (1993) Racial differences in the use of invasive cardiovascular procedures in the Department of Veterans Affairs medical system, *New England Journal of Medicine* 329: 600-606.
5. Rosenheck RA, Leda CL and Gallup PG (1992) Program Design and Clinical Operation of Two National VA Programs for Homeless Mentally Ill Veterans. *New England Journal of Public Policy* 8: 315-337.
6. Fontana A, Rosenheck R, and Spencer H. (1990) The Long Journey Home: The First Progress Report on the Department of Veterans Affairs PTSD Clinical Teams Program. Northeast Program Evaluation Center, Evaluation Division of the National Center for PTSD, Department of Veterans Affairs Medical Center, West Haven, Connecticut.
7. Fontana A, Rosenheck R, and Spencer H. (1992) The Long Journey Home II: The Second Progress Report on the Department of Veterans Affairs PTSD Programs. Northeast Program Evaluation Center, Evaluation Division of the National Center for PTSD, Department of Veterans Affairs Medical Center, West Haven, Connecticut.
8. Fontana A, Rosenheck R, and Spencer H. (1993) The Long Journey Home III: The Third Progress Report on the Department of Veterans Affairs PTSD Programs. Northeast Program Evaluation Center, Evaluation Division of the National Center for PTSD, Department of Veterans Affairs Medical Center, West Haven, Connecticut.
9. Sue S. Psychotherapeutic Service for Ethnic Minorities (1988) *American Psychologist* 43:301-308
10. Marsella AJ, Friedman MJ and Spain EH (1993) Ethnocultural aspects of PTSD: An overview of issues, research and directions, in JM Oldham, A Tasman and M Riba (Eds) *American Psychiatric Press Review of Psychiatry*, Washington, DC, American Psychiatric Press.
11. Kulka RA, Schlenger WE, Fairbank JA, Hough RL, Jordan BK, Marmar, CR and Weiss DA (1990) Trauma and the Vietnam War Generation: New York, Brunner/Mazel

Chapter 2 -

**Utilization of Mental Health Services by Minority
Veterans of the Vietnam Era**

by

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Abstract

Objective: This study sought to identify differences in utilization of mental health services among members of five minority groups who served in the military during the Vietnam era.

Methods: Data on utilization of mental health services from five different types of provider (VA mental health providers, non-VA mental health providers, non-psychiatrist physicians, clergy, and self-help groups) were obtained from a national survey of Vietnam era veterans (The National Vietnam Veterans Readjustment Study) along with information on sociodemographic characteristics, health status, income, and health insurance coverage. Chi-square tests and multivariate logistic regression analyses were used to compare use of various services among whites, blacks, Puerto Rican hispanics, Mexican hispanics and others.

Results: Blacks and Puerto Rican hispanics are more likely than whites to have used VA health services and, more specifically to have used inpatient VA mental health services. Both blacks and hispanics, in contrast, make less use than whites of non-VA mental health services. Black veterans and Mexican hispanic veterans were also significantly less likely than white veterans to have used self-help groups.

Conclusion. Although having served in the military during the Vietnam conflict may have alienated many minority veterans from the Federal government, the reluctance of minorities to use non-VA mental health services does not extend to the VA system. Further studies are needed to clarify the reasons for less non-VA service use among some minority groups.

I. Background

An important objective of the community mental health movement of the 1960s and 1970s was to increase the access of members of underserved minority groups to needed mental health services (1). Empirical studies conducted in recent years have suggested, however, that ethnocultural minorities have made less use of most types of professional mental health services than other Americans (2-9). Concern has also been expressed about underuse of mental health services, particularly those provided by the Department of Veterans Affairs, by minority group veterans who served in the military during the Vietnam conflict (10). This concern has been heightened by a recent study that showed that blacks and hispanics are more likely to suffer negative effects of military service than whites (11). By many accounts, the exceptionally painful and alienating experiences of members of ethnic minority groups who served in the armed forces (12-15) have resulted in considerable distrust of the government, its leaders and its institutions. In a 1980 survey of Vietnam veterans, 29% of black veterans and 27% of hispanic veterans agreed with the statement, "My country took unfair advantage of me," as compared to only 20% of whites (16). There is thus reason to examine whether the needs of minority veterans of the Vietnam era have been less well met than those of whites, and whether they may be especially reluctant to use VA services in particular.

Leading scholars have expressed concern at the lack of attention to ethnocultural and minority group issues in the treatment of warzone stress (17-18) and in psychiatric research more generally (19). In this study, we use data from a national survey of veterans who served during the Vietnam Era (the NVVRS; 11, 20) to compare rates of service utilization among veterans who are members of different ethnocultural groups, taking systematic account of other determinants of health service use as well. We examine two hypotheses: 1) that veterans belonging to major ethnic minority groups are less likely than white veterans to use professional mental health services, and 2) that minorities are, more specifically, less likely to use VA mental health services.

II. Methods

The NVVRS was conducted on a stratified national sample of veterans who served in the U.S. Armed Forces during the Vietnam Era. The sampling frame was a national screening sample of military personnel records and is described in detail in the original publications on the study (11, 20). Blacks and hispanics were systematically oversampled. The subsample used for this study included all male veterans surveyed in the NVVRS ($N=1,698$).

Following the framework developed by Anderson and colleagues (21), factors hypothesized to influence service utilization can be grouped into: 1) predisposing, 2) illness, and 3) enabling factors.

Predisposing factors are personal characteristics, existing prior to the onset of illness, that influence the use of health care services (e.g., age or ethnocultural group membership). Illness factors are the perceived health problems that provide the immediate impetus towards the use of health services. Enabling factors are the financial and/or insurance resources needed to obtain health care services. All measures used in the study are summarized in Table 2.1.

Predisposing factors measured for this study include sociodemographic factors (age, ethnocultural group, religious affiliation), family background, education, and military experience. Four additional measures of recent or current social adjustment that may reflect events that followed the onset of illness in some cases were also included, because they are assumed to reflect personal traits that are likely to influence service utilization. These measures concern criminal justice history, recent violent behavior, marital status, and work status.

Ethnocultural status was assessed through a series of questions concerning first, racial identity (black vs. white), then hispanic origin or descent and, finally, among those claiming hispanic descent, the specific national background or ancestry with which the veteran felt most closely identified. These responses were coded as Puerto Rican, Mexican or Other hispanic. Veterans who were both black and hispanic were excluded.

Religion was assessed through a single question concerning current religious preference. Measures of family background, which has been shown in other studies to affect service use independent of other factors (22), included questions concerning parental mental illness; whether the veteran was physically or sexually abused as a child; and a family instability index composed of 11 dichotomous items covering experiences before the age of 18 such as parental separation, divorce or death, or family income less than \$5,000 per year (23). A final area of family background concerned whether the veteran's father had ever served in combat.

Exposure of the veteran to war zone stressors was assessed by two variables: exposure to combat, measured by the Revised Combat Scale (24), and participation in abusive violence (code as a dichotomous variable, 1 = participated).

Criminal justice history was assessed with a criminal behavior index (1 = never in jail, 2 = jailed once, 3 = jailed more than once and 4 = imprisoned for a felony), and violent behavior by a seven-item scale which addressed issues such as the frequency with which a veteran destroyed property, threatened someone with physical violence, or was verbally abusive ($\alpha=0.80$). Marital and work status were reflected by dichotomous variables that reflected whether the veteran was currently married and currently working for pay.

Illness factors that were measured covered both psychopathology and physical functional impairment. Lifetime psychopathology was represented by three measures: 1) a dichotomous index of current Posttraumatic Stress Disorder, 2) a lifetime psychiatric illness index that comprised the total number of lifetime psychiatric diagnoses (excluding PTSD) using standard criteria from the American Psychiatric Association's Diagnostic and Statistical Manual, third edition, revised (DSM III-R) (25); and 3) a lifetime substance abuse index based on the number of lifetime DSM III-R substance abuse diagnoses (alcohol or drug abuse) for which the veteran met the criteria.

PTSD was assessed using a cutoff score of 89 on the Mississippi Scale for Combat-Related PTSD (26). In a related NVVRS validation study that used expert clinical interviews as its gold standard, the Mississippi Scale cutoff of 89 was shown to be the most accurate of several single measures of PTSD, with a sensitivity of 82% and specificity of 87% (20). All diagnoses other than PTSD were based on DSM III-R criteria as assessed with the Diagnostic Interview Schedule (DIS), a standardized, structured diagnostic interview (27).

Physical functional impairments were assessed through responses to fourteen questions concerning inability to perform tasks such as driving a car, getting around the community, doing vigorous exercise etc., that had lasted for more than three months. These responses were summed to create a physical impairment index ($\alpha = 0.88$).

Enabling factors measured in the NVVRS include personal income, receipt of VA benefits (which guarantees priority access to VA services), health insurance other than Medicaid, and Medicaid. The size of the city of residence was also included among the enabling characteristics because of the greater availability of medical services, and especially VA services, in large metropolitan areas. An additional enabling factor was the available supply of general health care services or mental health services, which has been shown to vary significantly across regions of the country (28). Current residence was coded using the Census Bureau's definitions of the major US regions (Northeast, Midwest, South and West). Because of its special importance to the study of ethnocultural issues, Puerto Rico was singled out from the four regions and coded separately.

Service use and attitudes towards mental health services. Veterans were asked if they had ever received help for a psychological or emotional problem from any one of eighteen different types of provider. For this study, these providers were classified into four groups: 1) mental health professionals (seen in either inpatient or outpatient settings); 2) physicians other than psychiatrists; 3) clergy (ministers, priests or rabbis), and 4) self-help groups, e.g., Alcoholics Anonymous (AA), Narcotics

Anonymous (NA), and veterans' rap groups. Use of VA health services was clustered into three categories: 1) lifetime use of VA mental health services (either inpatient or outpatient); 2) lifetime use of VA medical services; and 3) current use of VA services as the veteran's usual source of medical care. A fourth category, used for comparison with VA mental health service use, was constructed to represent lifetime non-VA mental health service use (i.e., mental health services provided by private practitioners, community mental health centers, social service agencies, hospital outpatient clinics, emergency rooms, or inpatient units).

A final "mental health utilization" category was constructed to reflect negative attitudes toward the use of mental health services, rather than the actual use of services. It has been suggested that the masculine role, among hispanics (29) as well as other minorities, "encourages endurance and silence in the face of distress rather than complaining about problems (30)." Veterans who had never sought help for an emotional or psychological problem were asked a series of questions concerning their attitudes towards such services. Among those who had never received services, 49% said they would never need services because they could always handle problems by themselves. The proportion of veterans in various ethnocultural groups who fell into this "never need" category, were evaluated in the same way as those in other service utilization categories.

Although receipt of VA compensation or pension benefits is considered here to be an enabling factor for use of VA health care services, it is also examined, in its own right, as an additional VA "service," providing another point of comparison when we consider differences in use of VA health care services by various ethnocultural groups.

Analyses. Chi-square tests were used to test whether there were significant differences in the proportion of veterans in each ethnocultural group who had used each type of service. A series of logistic regression analyses were then conducted to test the relationship of ethnocultural group membership and service use, after controlling for predisposing, illness and enabling factors.

Results

Veteran Characteristics Table 2.2 presents a comparison of ethnocultural groups on all predisposing, illness, and enabling characteristics. Among the many significant differences, it is notable that whites had more education, higher incomes and greater likelihood of being insured than other groups. Blacks came from more unstable families of origin and reported more criminal and recent violent behavior. Puerto Rican hispanics had more psychiatric disorder than Mexican hispanics. It is also notable that Puerto Rican hispanics, but not Mexican hispanics, had significantly more PTSD than whites.

Unadjusted Rates of Service Utilization. Table 2.3 shows the unadjusted rates of service utilization by each ethnocultural group. There were no significant differences among the groups in the use of services provided by mental health professionals, or by any other provider of mental health care. Significant differences among groups were evident, however, in the lifetime use of VA health care services and in current use of VA as the usual source of health care. Contrary to our hypothesis, Puerto Rican hispanics and blacks were the most frequent users of such VA services, while whites and Mexican Americans were the least frequent users.

Use of Professional Mental Health Services Logistic regression analyses revealed that the most important predictors of lifetime contact with a mental health professional were illness characteristics (Table 2.4), although parental mental illness, childhood physical abuse, education and criminal behavior were also significantly associated with seeking help from a mental health professional. After controlling for these factors, blacks and Mexican hispanics, but not Puerto Rican hispanics, were significantly less likely to have sought help from a mental health professional than white veterans. Blacks and Mexican hispanics were also less likely than other veterans to use self-help groups. As one would expect, health insurance and Medicaid coverage were both significantly related to use of general physician's services, and Protestant and Catholic religious affiliation were significantly associated with use of services provided by clergy.

The only significant relationships between ethnocultural status and the assertion that "I would never need help" for a mental health problem were a negative relationship with being Puerto Rican hispanic and a positive relationship with residing in Puerto Rico itself.

Utilization of VA Health Services After controlling for other factors, there were no significant relationships between minority group membership and use of VA mental health services (Table 2.5). Blacks and Puerto Rican hispanics were more likely than whites to have used VA medical services, and blacks were more likely than whites to regard VA as their usual source of care. In contrast, blacks and Mexican hispanics were less likely than whites to use non-VA mental health services. It is notable, for comparison purposes, that both Puerto Rican and Mexican hispanics were less likely than other veterans to have received VA financial benefits, a substantially different type of service from health care services.

Several significant relationships were noted with place of residence. First, receipt of both VA and non-VA mental health services was greater in large cities than in small cities or rural areas. Second, lifetime use of VA mental health services was significantly greatest in the Northeast; and lifetime use of any VA service was greatest in the Northeast, the Midwest and especially

in Puerto Rico. National data on VA mental health service delivery (31) show that, consistent with our findings, the supply of VA psychiatric services was considerably greater in the Northeast than in the rest of the country; and a review of VA administrative data for 1987 (32) showed that the high level of VA service use in Puerto Rico, as well as in the other regions, is also probably attributable to the greater supply of VA medical services in those areas.¹

Table 2.6 presents regression coefficients for ethnocultural minority use of both VA and non-VA mental health services, broken down by inpatient and outpatient service use. The reduced likelihood of non-VA service use among blacks and Mexican hispanics appears to be primarily attributable to low rates of outpatient service use.

Discussion

Data presented in this study generally confirm our first hypothesis, that veterans belonging to ethnocultural minority groups are less likely than others to use the services of mental health professionals. It is important to note, however, that: 1) this pattern did not pertain to all minorities (i.e., it was limited to blacks and Mexican hispanics), and 2) that the relationship was not specific to use of services provided by mental health professionals, but also appeared in the use of a very different service modality, self-help groups. These findings are generally consistent with other studies that have shown less professional mental health service use among minorities (2-9), and especially among blacks (8-9) and Mexican hispanics (7,33), with Puerto Rican hispanics using services at a frequency lying in between that of blacks, Mexican hispanics, and whites (34). Other researchers have likewise found that the relatively low utilization

¹ The inpatient psychiatric bed census in the Northeast in 1986 was 87 occupied beds per 1,000 veterans in the general population, as compared to only 66 occupied beds per 1,000 veterans in the rest of the country. VA mental health expenditures in the Northeast totaled \$53 per veteran in the general population, as compared to \$44 in the rest of the country. Outpatient admissions were also somewhat greater: 0.69 per veteran in the Northeast as compared to 0.64 per veteran elsewhere. These data were compiled from state figures reported by the National Institutes of Mental Health (31). In Puerto Rico, VA provided 2.9 outpatient visits (psychiatric and medical) per veteran in the general population in 1987, operated 5.5 hospital beds per 1,000 veterans (psychiatric and medical), and spent \$852 per veteran per year. On the mainland, taken as a whole, VA provided less than one-third as many outpatient visits per veteran (0.79/veteran), half as many beds (2.8 per 1,000 veterans) and spent half as many dollars (\$385/veteran) (32).

of mental health services among minorities is sometimes not apparent until adjustment is made for differing levels of need (35).

The reasons for underutilization of mental health services, and especially non-VA outpatient services, among minorities are unclear. Since our analyses control for income, health insurance, VA benefits, and regional supply factors, neither the greater rate of poverty among minorities nor differences in their geographical distribution would seem to explain the observed differences in service utilization. While it is possible that minority group cultures discourage help-seeking in some way, our data, at first glance, indicate that among those who have never used mental health services, members of minorities are no more likely than whites to feel that they would never need mental health services.

On the other hand, since the reluctance of minorities to use mental health services extends to self-help groups (the virtual antithesis of mental health professionals) it would seem that we may be dealing with something more than a discomfort with the formality of professional services. Even if minority group members are no more likely than whites to feel they would "never" need help with an emotional problem, a subtler discomfort in obtaining help for emotional problems from people outside of the family or beyond informal social support networks might still be quite important. The lower utilization of both professional mental health services and self-help groups among Mexican hispanics as compared to Puerto Rican hispanics is a case in point.

In an analysis of cultural value orientations, Papajohn and Spiegel (36) suggested that, in the Mexican hispanic culture, the most important social ties are with kin networks, and that humankind is viewed as largely powerless before the forces of nature. In Puerto Rican culture, in contrast, collateral relationships with a larger non-kin network are highly valued and people are not viewed as powerless. Puerto Rican values, in this analysis, can be seen to be more compatible with seeking help from professional "change" experts outside of the family than those of Mexican hispanics.

It is also possible that, since the majority of health professionals in this country are white, minorities are inhibited from using services by some degree of cross-cultural distrust (37-39). Although some clinicians and some simulation experiments have suggested that minorities do poorly when treated by clinicians from other ethnocultural groups, most empirical studies have shown few differences in clinical outcome between ethnocultural minorities (40). Careful studies of medical care have found similarly unexplained underutilization of services by minorities (41-42). Such differences may represent inequities in our health care system, are poorly understood, and need to be studied further and remedied.

The data presented strongly disconfirmed our hypothesis that minorities would also be less likely to use VA mental health services, showing rather that blacks and Mexican hispanics were less likely than whites to use non-VA services, especially outpatient services, but were no less likely than whites to use VA services. Blacks, in fact, appeared to be more likely than whites to use VA inpatient mental health treatment, VA medical services, and to regard VA as their usual source of health care. A previous study, which included World War II and Korean era veterans, has also reported that black veterans are more likely than others to use VA health care services (43) even after the influences of income, receipt of VA benefits, and health status have been taken into consideration.

Although it is commonly assumed that bitter feelings about racial tensions in the military have discouraged minority veterans from seeking help from the VA health care system, this assumption was not borne out by our data. It should be remembered, however, that in addition to its central role in the initiation and conduct of the Vietnam conflict, the Federal government has also played a visible, central, and often leading role in the expansion of civil rights during the last century, from the Presidency of Abraham Lincoln to that of Lyndon Johnson, and from the 14th Amendment to the Constitution in 1868, to desegregation of the Armed Forces in 1947, and the Voting Rights Act of 1965. Minority group veterans may feel that, even if American society remains unjust, they can get fairer treatment from an institution operated by the Federal government than elsewhere. It appears that, on the whole, in the health care domain, and where VA is concerned, the forces of affiliation are stronger than the forces of alienation.

References

1. Sue S (1977) Community Mental Health Services to Minority Groups. *American Psychologist* 32: 616-624
2. Lefley HP (1990) Culture and Chronic Mental Illness, Hospital and Community Psychiatry 41: 277-286.
3. Acosta FX (1980) Self-described reasons for premature termination of psychotherapy by Mexican American, black American and Anglo-American patients.; *Psychological Reports*, 47:435-443
4. Watts CA, Scheffler RM and Jewell NP (1986) Demand for Outpatient Mental Health Services in a Heavily Insured Population, *Health Services Research* 21: 267-290
5. Horgan CM (1986) The Demand for Ambulatory Mental Health Services from Specialty Providers, *Health Services Research* 21: 291-320.
6. Leaf PJ, Bruce ML, Tischler GL, Freeman DH, Weissman ML and Myers JK (1988) Factors Affecting the Utilization of Specialty and General Medical Mental Health Services, *Medical Care* 26: 9-26.
7. Wells KB, Hough RL, Golding JM, Burnam MA and Karno M (1987) Which Mexican-Americans Underutilize Health Services? *American Journal of Psychiatry* 144:918-922.
8. Solomon P (1988) Racial Factors in Mental Health Service Utilization, *Psychosocial Rehabilitation Journal* 11: 3-12.
9. Mollica RF, Blum JD and Redlich F (1980) Equity and the Psychiatric care of the Black Patient, 1950-1975, *Journal of Nervous and mental Disease* 168: 279-286
10. Scott K (1993) Minority Health: VA Efforts Questioned, *U.S. Medicine*, 19: 22-23 (October 1993).
11. Kulka RA, Schlenger WE, Fairbank JA, Hough RL, Jordan BK, Marmar, CR and Weiss DA (1989) Trauma and the Vietnam War Generation: Report of Findings from the National Vietnam Veterans Readjustment Study. New York, Brunner/Mazel.
12. Terry W (1984) *Bloods: An Oral History of the Vietnam war by Black Veterans*, New York, Random House.
13. Parson ER (1985) Ethnicity and Traumatic Stress: The Intersecting Point in Psychotherapy, in CR Figley (Ed) *Trauma and Its Wake*, Volume I. New York, Brunner/Mazel.

14. Parson ER (1985) The Black Vietnam Veteran: His Representational World, in WE Kelley (Ed.) Post-Traumatic Stress Disorder and the War Veteran Patient, New York, Brunner/Mazel.
15. Silver SM and Wilson JP (1988) Native American Healing and Purification Rituals for War Stress, in JM Wilson, Z Harel and B Kahana (Eds) Human Adaptation to Extreme Stress: From the Holocaust to Vietnam, New York, Plenum.
16. Myths and Realities: A Study of Attitudes Towards Vietnam Era Veterans (1980) A Report submitted by the Veterans Administration to the Committee on Veterans Affairs, United States Senate, Washington, DC.
17. Marsella AJ, Friedman MJ and Spain EH (1993) Ethnocultural aspects of PTSD: An overview of issues, research and directions, in JM Oldham, A Tasman and M Riba (Eds) American Psychiatric Press Review of Psychiatry, Washington, DC, American Psychiatric Press.
18. Westermeyer J (1989) Cross-cultural care for PTSD: Research, training and service needs for the future. Journal of Traumatic Stress 2:515-536.
19. Lawson W (1986) Racial and Ethnic Factors in Psychiatric Research, Hospital and Community Psychiatry 37: 50-54.
20. Kulka RA, Schlenger WE, Fairbank JA, Hough RL, Jordan BK, Marmar, CR and Weiss DA (1990) The National Vietnam Veterans Readjustment Study: Tables of Findings and Technical Appendices. New York, Brunner/Mazel.
21. Anderson RF and Newman JF (1973) Societal and individual determinants of medical care utilization in the United States. Milbank Memorial Fund Quarterly; 51: 95-124.
22. Williams DR, Lavizzo-Mourne R and Rueben W (1994) The concept of race and health status in America, Public Health Reports 109: 26-41.
23. Kadushin C, Boulanger G, and Martin J (1981) Legacies of Vietnam. Vol. IV. Long Term Stress Reactions: Some Causes, Consequences, and Naturally Occurring Support Systems; House Committee Print No. 14, U.S. Government Printing Office, Washington, D.C.
24. Laufer RS, Yager T, Frey-Wouters E, and Donnellan J (1981) Legacies of Vietnam. Vol. III. Post-War Trauma: Social and Psychological Problems of Vietnam Veterans and Their Peers; House Committee Print No. 14, U.S. Government Printing Office, Washington, D.C.

25. American Psychiatric Association (1987) Diagnostic and Statistical Manual (Third Edition) Revised. Washington, DC, American Psychiatric Association.

26. Keane TM, Caddell JM, Taylor, KL (1988) The Mississippi scale for combat related PTSD: Studies in reliability and validity. *Journal of Consulting and Clinical Psychology* 56: 85-90.

27. Robins LN, Helzer JE, Croughan, et al (1981) The National Institute of Mental Health Diagnostic Interview Schedule. *Archives of General Psychiatry* 38: 381-389.

28. Rosenheck RA and Astrachan BM (1990) Regional Variation in Patterns of Psychiatric Inpatient Care. *American Journal of Psychiatry* 147: 1180-1183.

29. Barcerra R The Hispanic Vietnam Veteran: Mental Health Issues and Therapeutic Approaches, in R Barcerra (Ed) *Mental Health and Hispanic Americans*, New York, Grune and Stratton.

30. Marsella AJ, Chemtob C and Hamada R (1990) Ethnicultural Aspects of PTSD in Vietnam War Veterans, *National Center for PTSD Clinical Newsletter*, 1 (2):1-4.

31. Redick RW, Witkin MJ, Atay JE and Manderscheid RW (1992) Specialty Mental Health System Characteristics, in RW Manderscheid and MA Sonnenschein (Eds.) *Mental Health 1992*, Washington DC, US Department of Health and Human Services.

32. Veterans Administration (1988) Annual Report of the Veterans Administration: Fiscal Year 1987. Washington, DC,

33. Hough RL, Landsverk JH, Karno M, Burnam MA, Timbets DT, Escobar JI and Regier DA (1987) Utilization of Health and Mental Health Services by Los Angeles Mexican Americans and Nonhispanic whites. *Archives of General Psychiatry*, 44: 702-709.

34. Schur CL, Bernstein AB and Berk ML (1987) The Importance of Distinguishing Hispanic Subpopulations in the Use of Medical Care, *Medical Care* 25: 627-641.

35. Meinhardt K and Vega W (1987) A Method for Estimating Underutilization of Mental Health Services by Ethnic Groups, *Hospital and Community Psychiatry* 38: 1186-1190.

36. Papajohn J and Speigel J (1975) *Transactions in Families*, San Francisco, Jossey-Bass.

37. Parson ER (1985) The Intercultural Setting: Encountering Black Vietnam Veterans, in Sonnenberg S, Blank AS and Talbott JA (eds) *The Trauma of War: Stress and Recovery in Vietnam Veterans*, Washington, DC, American Psychiatric Press, 1985.

38. Penk WE and Allen IM (1989) Clinical Assessment of Post-Traumatic Stress Disorder (PTSD) Among American Minorities who Served in Vietnam, *Journal of Traumatic Stress* 4:41-66.

39 Jackson GJ (1977) Cross-cultural Counselling with Afro-Americans, in P Pederson (Ed) *Handbook of Cross-Cultural Counseling and Therapy*. Westport, CT, Greenwood Press.

40. Sue S. Psychotherapeutic Service for Ethnic Minorities (1988) *American Psychologist* 43:301-308.

41. Cowies MR, Fahrenbruch CE, Cobb LE, Hallstrom AP (1993) Out-of-hospital cardiac arrest: racial differences in outcome in Seattle. *Am J Public Health* 83:948-954.

42. Escarce JJ, Epstein KR, Colby DC, Schwartz JS (1993) Racial differences in the elderly's use of medical procedures and diagnostic tests. *Am J Public Health* 83:948-954.

43. Rosenheck RA and Massari LA (1993) Wartime Military Service and Utilization of VA Health Care Services. *Military Medicine* 158: 223-228.

Table 2.1. Variables, means, standard deviations and ranges
for the total sample (N=1,698)(1).

	Mean	S.D.	Range
Predisposing Factors			
Age	41.90	6.60	29-60
Black	0.27	0.45	0-1
Puerto Rican	0.05	0.22	0-1
Mexican	0.15	0.35	0-1
Protestant	0.54	0.50	0-1
Catholic	0.30	0.46	0-1
Parental mental illness	0.21	0.41	0-1
Family instability	2.81	1.88	0-11
Childhood physical abuse (2)	0.42	0.94	0-4
Father in combat	0.23	0.43	0-1
Education	13.36	2.46	1-20
Combat exposure	5.49	5.03	0-1
Abusive violence in VN	0.24	0.43	0-1
Criminal behavior	1.59	0.92	1-4
Violence	7.48	4.20	0-7
Married	0.73	0.44	0-1
Working	0.85	0.36	0-1
Illness factors			
PTSD	0.22	0.41	0-1
Psychiatric Diagnoses	0.29	0.76	0-6
Substance Abuse	0.45	0.61	0-2
Physical Disability	1.10	2.20	0-14
Enabling factors			
Personal Income (\$000's)	25.79	13.48	0-50
VA Benefits	0.19	0.39	0-1
Insurance	0.86	0.35	0-1
Medicaid	0.02	0.14	0-1
City Size (3)	1.93	0.90	1-3
Services			
Mental health professional	0.27	0.44	0-1
Lifetime VA mental health	0.10	0.30	0-1
Lifetime non-VA mental health care	0.21	0.38	0-1
Clergyperson	0.12	0.32	0-1
Physician	0.09	0.28	0-1
Self-help group	0.07	0.26	0-1
Would never need help (4)	0.49	0.47	0-1

(1) Where range is 0-1, mean is equivalent to percent

(2) Four level scale based on severity

(3) 1= <250,000; 2= >250,000<1,500,000; 3= >1,500,000

(4) Among those who have not used mental health services

Table 2.2. Veteran characteristics, by ethno-cultural group.

	White-1 (N=800)	Black-2 (N=458)	Hispanic-3 Puerto Rican (N=247)	Hispanic-4 Mexican (N=103)	Other-5 (N=90)	Significant differences (3)
Predisposing Characteristics						
Age	42.25	43.03	40.45	40.60	40.97	1>4, 2>3, 4, 5
Protestant	0.54	0.82	0.20	0.18	0.41	1>3, 4, 5; 2>1, 3, 4, 5; 5>3, 4
Catholic	0.25	0.08	0.73	0.69	0.37	1>2; 3>1, 2, 5; 4>1, 2, 5; 5>1, 2
Parental mental illness	0.24	0.18	0.23	0.18	0.22	1>2
Family instability	2.46	3.22	2.71	3.27	2.96	2>1, 4>1
Childhood physical abuse (1)	0.44	0.30	0.40	0.36	0.71	5>1, 2, 4
Father in combat	0.27	0.17	0.14	0.23	0.32	1>2; 5>2, 3
Education	13.57	13.12	13.88	13.02	13.19	1>2, 4; 3>4
Combat exposure	5.27	5.63	5.65	5.30	5.51	
Abusive violence in VN	0.23	0.25	0.22	0.24	0.25	
Criminal behavior	1.43	1.78	1.38	1.78	1.57	2>1, 3; 4>1, 3
Violence	7.08	7.87	7.78	7.84	7.76	2>1
Married	0.78	0.61	0.76	0.73	0.79	2<1, 3, 4, 5
Working	0.87	0.77	0.88	0.86	0.83	1>2, 4>2
Illness characteristics						
PTSD	0.18	0.26	0.33	0.22	0.25	2>1, 3>1
Psychiatric Diagnoses	0.28	0.30	0.50	0.24	0.31	3>4
Substance Abuse	0.46	0.45	0.46	0.59	0.44	4>1, 2
Physical Disability	1.12	1.27	1.18	0.80	1.18	
Enabling characteristics						
Personal Income	28.62	22.06	23.02	24.35	27.04	1>2, 3, 4; 5>2
VA Benefits	0.20	0.22	0.17	0.09	0.19	1>4; 2>4
Insurance	0.89	0.80	0.83	0.84	0.86	1>2
Medicaid	0.01	0.03	0.04	0.01	0.03	2>1
City size (2)	1.68	2.27	2.19	2.06	1.89	2>1, 4, 5; 3>1; 4>1
Region						
Northeast	0.21	0.13	0.38	0.00	0.14	1>2, 4; 2>4; 3>1, 2, 4, 5; 5>2
Midwest	0.23	0.17	0.04	0.08	0.17	1>2, 3, 4; 2>3, 4
South	0.33	0.57	0.10	0.36	0.21	1>3; 2>1, 3, 4, 5; 4>3, 5
West	0.22	0.14	0.09	0.56	0.46	1>2, 3; 4>1, 2, 3; 5>1, 2, 3
Puerto Rico	0.00	0.00	0.39	0.00	0.01	3>1, 2, 4, 5

(1) Four level scale based on severity.

(2) 1= < 250,000; 2= > 250,000 <1,500,000; 3= > 1,500,000

(3) Statistical comparisons are based on ANOVAs with Tukey multiple range test for paired comparisons ($p<.05$)

Table 2.3. Veteran use of services, by ethnocultural status.

	White (N=800)	Black (N=458)	Rican (N=90)	Puerto Rican Mexican (N=247)	Hispanic Other (N=103)	Chi Sq. (p)
Total Sample of Veterans (N=1,698)						
Use of General sources of help for emotional problems						
Mental health professional	28.2%	23.1%	27.8%	23.9%	33.0%	7.1
Physician	8.5%	8.5%	12.2%	6.1%	13.6%	6.8
Clergy	12.4%	12.7%	10.0%	8.5%	11.7%	3.5
Self-help group	7.5%	6.1%	4.5%	5.7%	12.6%	7.4
Use of VA services						
Lifetime VA mental health	8.4%	11.6%	13.6%	8.2%	11.7%	6.0
Any lifetime VA health care	27.4%	40.8%	53.3%	21.5%	31.1%	55.9
VA usual source of medical care	4.6%	17.3%	8.9%	6.1%	1.9%	69.5
Lifetime Non-VA mental health	23.8%	17.3%	22.2%	17.0%	7.8%	12.3
VA benefits	19.9%	22.1%	16.7%	8.9%	19.4%	20.0
Veterans who had never used mental health services (N=1,228)						
Would never need MH services	48.1%	47.4%	46.4%	54.3%	56.3%	0.48

Table 2.4. Logistic regression analysis of mental health service use, by source (1).

	Mental Health Prof.(4)	Physician	Clergy	Self-help group	Never Need Help
Percent positive	25.3%	8.5%	11.9%	7.1%	7.3%
Model N=	1,576	1,576	1,576	1,576	1,134
R-squared	0.23	0.07	0.08	0.18	0.08
Predisposing Characteristics					
Age	0.02	0.00	-0.07	0.08	-0.05
Black	-0.11 b	-0.05	-0.03	-0.17 b	-0.01
Puerto Rican	-0.08	0.01	-0.00	-0.10	-0.11 a
Mexican	-0.07 a	-0.06	-0.08	-0.16 b	0.00
Protestant	-0.11 b	0.03	0.21 c	-0.03	0.00
Catholic	-0.05	-0.06	0.14 a	-0.00	0.10 b
Parental mental illness	0.11 c	0.09 a	0.12 c	0.11 b	-0.03
Family instability	-0.02	-0.04	0.05	-0.03	-0.00
Childhood physical abuse (2)	-0.02	-0.07	-0.05	-0.09	-0.07 a
Father in combat	0.03	0.02	-0.04	0.05	-0.02
Education	0.10 b	-0.05	0.14 c	0.10	-0.07 a
Combat exposure	-0.00	0.01	-0.11 a	0.08	0.07 a
Abusive violence in VN	0.01	0.01	-0.01	-0.03	-0.03
Criminal behavior	0.12 c	0.00	0.08 a	0.26 e	-0.08 b
Violence	0.01	0.05	-0.06	0.11 a	-0.04
Married	-0.15 e	-0.05	-0.04	-0.19 c	-0.05
Working	-0.06	0.02	-0.03	-0.07	-0.05
Illness characteristics					
PTSD	0.16 d	0.09 a	0.13 b	0.07	-0.13 c
Psychiatric Diagnoses	0.25 e	0.15 d	0.18 e	0.05	-0.14 d
Substance Abuse	0.21 e	0.16 c	0.10 b	0.37 e	-0.06
Physical Disability	0.10 c	0.08 a	0.01	0.03	-0.05
Enabling characteristics					
Personal Income	0.01	0.01	0.01	0.05	-0.03
VA Benefits	0.04	0.08	-0.06	0.11 a	0.08 b
Insurance	0.03	0.13 b	0.05	0.12 a	0.01
Medicaid	0.03	0.08 a	-0.05	0.11 c	-0.04
City size (3)	0.09 b	0.01	0.02	0.01	0.04
US Region					
Northeast	0.08 a	0.10 a	-0.04	-0.09	0.01
Mid West	0.01	0.02	0.01	-0.04	-0.01
South	-0.01	0.09	0.01	-0.10	0.04
Puerto Rico	-0.00	0.01	-0.16 a	-0.07	0.09 a

(1) Key to significance of adjusted regression coefficients.

a = p < 0.10

b = p < 0.05

c = p < 0.01

d = p < 0.001

e = p < 0.0001

(2) Four level scale based on severity.

(3) 1=<250,000; 2=>250,000 <1,500,000; 3=> 1,500,000

(4) Includes either inpatient or outpatient care.

Table 2.5. Logistic regression analyses of use of VA and non-VA services (1).

	VA Mental Health	Lifetime VA Svc. Use	VA Usual Source of Care	Non-VA Mental Health	VA Bene- fits
Percent positive	9.5%	31.9%	8.0%	21.1%	18.5%
Model N=	1,575	1,576	1,576	1,575	1,576
R-squared	0.33	0.28	0.25	0.16	0.17
Predisposing Characteristics					
Age	0.11	-0.07 a	0.13 b	0.01	0.19 e
Black	0.00	0.14 d	0.28 e	-0.13 c	0.00
Puerto Rican	0.05	0.11 b	0.08	-0.08	-0.12 a
Mexican	0.01	-0.04	0.08	-0.11 b	-0.18 c
Protestant	-0.05	-0.11 b	0.08	-0.09 a	0.13 b
Catholic	0.06	-0.06	0.05	-0.04	0.14 b
Parental mental illness	0.11	0.00	-0.07	0.10 c	0.04
Family instability	0.16 b	0.05	-0.02	-0.04	0.08 a
Childhood physical abuse (2)	-0.04	0.06 a	0.04	-0.01	0.00
Father in combat	-0.07	-0.05	-0.09	0.02	-0.01
Education	0.02	-0.03	-0.04	0.12 c	0.10 b
Combat exposure	0.14 a	0.18 e	0.06	-0.02	0.38 e
Abusive violence in VM	-0.06	-0.03	-0.02	0.01	-0.02
Criminal behavior	-0.01	0.04	0.07	0.11 c	0.06
Violence	-0.05	-0.01	-0.09	0.02	
Married	-0.04	-0.00	-0.02	-0.16 e	0.09 b
Working	-0.02	0.04	-0.01	-0.03	
Illness characteristics					
PTSD	0.20 d	0.06	0.11 a	0.10 b	0.04
Psychiatric Diagnoses	0.28 e	0.11 c	0.15 c	0.17 e	0.06
Substance Abuse	0.21 c	0.02	0.07	0.21 e	0.05
Physical Disability	0.11 b	0.06	0.10 b	0.07 a	0.28 e
Enabling characteristics					
Personal Income	-0.38 e	-0.19 e	-0.44 e	0.03	
VA Benefits	0.23 e	0.43 e	0.32 e	-0.02	
Insurance	0.03	0.03	-0.07	0.03	
Medicaid	-0.06	0.01	0.01	0.02	
City size (3)	0.16 b	0.02	0.14 b	-0.07 a	
US Region					
Northeast	0.12 a	0.07 a	-0.05	0.06	0.05
Mid West	0.01	0.11 c	0.00	-0.01	0.01
South	0.01	0.07	0.01	-0.02	0.01
Puerto Rico	0.05	0.10 b	-0.02	-0.01	0.07

(1) Key to significance of adjusted regression coefficients.

a = p< 0.10

b = p< 0.05

c = p< 0.01

d = p< 0.001

e = p< 0.0001

(2) Four level scale based on severity.

(3) 1=<250,000; 2=>250,000 <1,500,000; 3=> 1,500,000

Table 2.6. Logistic regression analysis of use of VA and non-VA mental health services, by inpatient and outpatient categories (1).

	-- VA Services --		-- non-VA Services --	
	Inpatient	Outpatient	Inpatient	Outpatient
Percent Positive	4.4%	8.9%	5.8%	21.1%
Model N=	1,576	1,576	1,576	1,576
R-squared	27.4%	31.9%	26.4%	15.5%

Black	-0.14 a	-0.01	0.03	-0.13 c
Puerto Rican	-0.01	-0.04	-0.01	-0.08 a
Mexican	-0.01	-0.03	-0.02	-0.11 c

(1) Coefficients for covariates included in Tables 2.5 and 2.6 are not shown.

Key to significance of adjusted regression coefficients.

a = p < 0.10

b = p < 0.05

c = p < 0.01

d = p < 0.001

e = p < 0.0001

Chapter 3 -

**Ethnocultural Variations In Service Utilization
and Clinician-Assessed Improvement
Among Veterans Suffering from PTSD**

by

Robert Rosenheck MD and Alan Fontana PhD

Abstract

Background: In this study, we consider the relationship of minority group membership to past use of mental health care services and to clinician-rated outcome of treatment among veterans seeking help for combat-related PTSD.

Methods: As part of the national evaluation of VA's PTSD Clinical Teams (PCT) Program, a detailed examination was conducted of past and current treatment received by veterans who came to VA for help with psychological problems related to their war zone experiences. Five ethnocultural groups were compared: whites, blacks, hispanics of Puerto Rican origin, hispanics of Mexican origin and others.

Results: Blacks reported a greater need than whites for help with financial support, employment, and alcohol and drug abuse. Consistent with their expressed needs, they made greater use of substance abuse services, but less use of psychiatric services or psychotropic medication. Greater symptomatology and use of abreactive therapies were observed among hispanics, especially Puerto Rican hispanics, and are consistent with other epidemiologic studies. Although there were few differences between groups on most measures of service use, blacks participated in treatment for shorter periods of time than white veterans, and had fewer treatment sessions. They were rated by their clinicians as showing less improvement than whites on 3 of 16 such measures.

Conclusion: This study identified some significant differences between ethnocultural groups in service utilization and clinical improvement. Most of these differences are explained by epidemiologic and cultural factors that exist independently of service system characteristics, and are similar to findings reported in other studies. The evidence of less involvement in treatment among blacks, and less clinician rated improvement, however, is not fully explained by any of the factors we have examined and calls for additional study.

I. Background

For as long as there have been civilizations, from the time of Odysseus' long journey home from the Trojan War to the modern day pilgrimages of American veterans to the Vietnam Veterans Memorial in Washington, nations have searched for ways to heal the physical and psychological wounds of war. Self-reliance and a distaste for government assistance, especially as the latter involves the Federal government, have long been central values in American political culture (1). The sense of obligation to the nation's veterans, however, has been the major exception to this principle (2). As described in a recent monograph (3), federal assistance to veterans was the largest and perhaps the most important forerunner of the federal social welfare programs that proliferated in America during the twentieth century; and the nation's vast complex of federal, state and voluntary veterans assistance programs are still our longest running effort in the area of welfare democracy.

One of the distinctive features of our democratic nation state, in contrast to the European monarchies from which it sprung, is that military service, at all levels, is the responsibility and obligation of the citizenry, not of an aristocratic elite (4). In principle, if not always in fact, our nation adheres to the ideal that the armed forces should reflect the universality of opportunity and the respect for diversity that are among our most cherished national ideals. Racial minorities and women have been the largest growing segments of our armed forces since the end of the Vietnam conflict. Recent controversies over the participation of women in combat roles specifically, and of homosexuals in the military more generally, illustrate the incompleteness with which we have achieved the ideal of a representative military, but also the continued efforts to attain that ideal.

Empirical studies conducted in recent decades have suggested that ethnocultural minorities make less use of both physical and mental health services than other Americans, either because they lack the resources needed to pay for such services, or because they are personally reluctant to use such services, or because they have encountered service providers who are insensitive to their distinctive values and traditions (5-8). There have been many accounts of the exceptionally painful and alienating experiences of members of ethnic minority groups who served in the armed forces (9-12). Minority troops have often found themselves risking their lives for a society that accorded them only second-class status at home, and as a result, many felt deeply alienated from their government and from its leaders (10). In a 1980 survey of Vietnam veterans, for example, 29% of black veterans and 27% of hispanic veterans agreed with the statement, "My country took unfair advantage of me," as compared to only 20% of whites (13).

Those who are responsible for serving America's veterans are thus confronted with the challenge of providing assistance to a

clearly entitled but ethnoculturally diverse, often politically alienated, and geographically dispersed population. There has been virtually no empirical examination of how successful we have been at delivering health care and other benefits to members of ethnocultural minorities who have sustained injuries and other hardships as a result of their military service.

Leading scholars have expressed concern at the lack of attention to ethnocultural and minority issues in the treatment of PTSD specifically (14-15) and in psychiatric treatment generally (16). Specific attention to services provided to ethnocultural minorities is especially warranted in the evaluation of the nation's treatment of its wartime veterans. In a previous study (17), we used data from a national community sample of veterans who served during the Vietnam conflict (the National Vietnam Veterans Readjustment Study) (NVVRS) (18-19) to test two hypotheses: 1) that veterans from ethnocultural minority groups are less likely than other veterans to use services of mental health professionals, and 2) that, because of their alienation from the government, they are especially less likely to use VA mental health services. Contrary to these hypotheses, no differences were observed in rates of professional mental health service utilization among five different ethnocultural groups (whites, blacks, Puerto Rican hispanics, Mexican hispanics and others) until adjustments were made for severity of need or resource availability. When adjustments were made for these other factors, black and Mexican hispanic veterans were less likely to use professional mental health services than other veterans, but they were also less likely to make use of self-help groups such as Alcoholics Anonymous as well. Minority groups were just as likely as whites, however, to use VA mental health services, even after adjustment was made for factors such as income, health insurance and receipt of VA financial benefits. In contrast, after adjusting for these factors, black and Mexican hispanic veterans were less likely than whites to use non-VA mental health services.

We concluded from those findings that, in spite of the central role of the Federal government in the Vietnam conflict, feelings of alienation among minority veterans of the Vietnam era have not dissuaded them from turning to VA for help. Perhaps more important than its involvement in the Vietnam conflict is the fact that the Federal government has played a visible and often leading role in the expansion of civil rights, from the 14th Amendment to the Constitution in 1868, to the desegregation of the Armed Forces in 1948, to the Voting Rights Act of 1965. It appears that embittered minorities feel that, even if American society remains unjust, they get the fairest chance at treatment from an institution operated by the Federal government. The forces of affiliation with VA thus appear to be more important than the forces of alienation.

In this report, we extend our examination of ethnocultural factors in the treatment of combat-related PTSD through a detailed

examination of treatment received by veterans who come to VA for help with psychological problems related to their war zone experiences. Data for this study are derived from structured interviews conducted as part of the national evaluation of the implementation of the Department of Veterans Affairs PTSD Clinical Teams (PCT) program. Fifty-three Teams were established across the country by VA between 1989 and 1992, with the task of providing war zone veterans with treatment of PTSD in specialized outpatient clinical settings.² This study explores differences between ethnocultural minority groups in five related domains: 1) sociodemographic status and baseline clinical presentation, 2) self-identified service needs; 3) past service utilization; 4) prospectively examined use of Team services during the year following first contact with the program; and 5) clinical improvement as assessed by Team clinicians at the time of the last clinical contact. We thus hoped to determine whether there are differences between minority groups in clinical problems and self-identified needs, in receipt of services, and in benefit from services.

It must be noted that the data used in this study were not collected specifically to evaluate the influence of ethnocultural background or current ethnocultural orientation on the utilization or effectiveness of mental health treatment. Consequently, the information on ethnocultural identity available in these studies is rudimentary, and the categorizations of illness and health care services are those of conventional American culture, not, as one might prefer, those of the informants themselves (20).

II. Methods

The Department of Veterans Affairs PTSD Clinical Teams Program. As part of the national evaluation of the implementation of VA's PCT program, the first 100 veterans seen at 53 VA sites received a formal assessment using a structured interview instrument, the War Stress Interview, Part 1 (WSI-1)(21-22). The WSI-1 was administered by program clinicians during the implementation phase of the program. The progress of veterans in treatment was documented for one year thereafter using the Clinical Process Form (CPF), a structured clinical summary completed by PCT clinicians 2, 4, 8 and 12 months after each veteran entered treatment.

Instruments.

The WSI-1 assessed veterans' baseline characteristics in five broad domains: 1) sociodemographic characteristics (age, race,

² Nine of these Teams were Substance Use PTSD Treatment Teams (SUPTs) that specialize in the treatment of veterans whose PTSD is complicated by substance abuse.

marital status, employment, income, and receipt of VA compensation benefits), 2) exposure to war zone trauma, 3) clinical status (PTSD and other psychiatric symptoms, substance abuse disorders and medical problems), 4) past VA and non-VA mental health service use, and 5) areas of clinical need, as identified by the veteran.

CPF reports allowed determination of: 1) the length of veterans' participation in treatment with the Team up to one year; 2) the number of treatment sessions; 3) the clinicians' assessment of regularity of attendance and commitment to treatment during the first two months of treatment; 4) the overall content focus of treatment; and 5) the clinicians' assessment of improvement in 16 areas at the time of last contact.

Measures

Six ethnocultural groups were distinguished: whites, blacks, Puerto Rican hispanics, Mexican hispanics, American Indians, and others). Unfortunately, WSI-1 did not ask specifically about Hispanic subgroup identification. Using residence data from the NVVRS as a guide, a determination was made by site location between Hispanics who were likely to be of Puerto Rican descent and those who were likely to be of Mexican descent.

Exposure of the veteran to war zone stressors was assessed by two variables: exposure to combat, as measured by the Revised Combat Scale (23), and participation in abusive violence.

PTSD symptoms were measured as the mean of responses to the Structured Clinical Interview for Diagnosis (24) concerning the DSM III-R criteria for PTSD, while general psychiatric problems were assessed using the psychiatric subscale of the Addiction Severity Index (ASI) (25). Alcohol abuse was assessed using the four "CAGE" items (26), and drug abuse with selected items from the Diagnostic Interview Schedule (DIS) (27, 28). The presence of medical problems was evaluated with a single question asking if the veteran suffered from a serious medical problem.

An extensive series of questions addressed past use of VA and non-VA inpatient and outpatient services for psychiatric, substance abuse and medical problems, as well as overall satisfaction with VA mental health services. At the conclusion of the WSI-1 interview, each veteran was presented with a list of 15 clinical and social adjustment problem areas, and was asked to identify all areas in which he or she felt a need for additional help.

Treatment provided by the Team was tracked using the CPF. General patterns of attendance were assessed after two months using a three level question (1=attended only once or twice; 2=attendance has been continuing but irregular; 3=attendance quite regular). Commitment to working with the Team was also assessed after two months, on a five point scale (0=not at all committed; 2=slightly committed; 2=moderately committed; 3=highly committed;

4=maximally committed). Content focus was addressed through a question that asked, overall, how much of the total clinical time was spent on 21 general clinical modalities and 10 specific clinical activities (0=no time; 1=a little time (less than 10%); 2=some time (between 10% and 50%) and 3=a lot of time (more than 50%). Clinical improvement since initiation of contact with the program was measured for 16 domains on a 5-point scale (0=substantial deterioration; 1=some deterioration; 2=no change; 3=some improvement; 4=substantial improvement). Only those who were identified as having a problem in each domain were rated. Since there could be more than one CPF per veteran, data on therapeutic content focus were averaged across all CPFs for each veteran. The improvement rating used was the one reported on the last CPF for each veteran.

Analyses

One-way analyses of variance (ANOVA), with Tukey multiple-range tests, were used to evaluate the statistical significance of differences in various measures of clinical status and service utilization. In the analysis of veterans' assessment of their own needs, of past service utilization and of clinician-assessed improvements, the potentially confounding influence of sociodemographic and clinical factors that differed significantly across ethnocultural group membership, as well as site differences, was statistically controlled by analysis of covariance (ANCOVA).

III. Results

Ethnocultural group membership

The sample included 3,879 whites (70.8%), 918 blacks (16.8%), 249 Puerto Rican hispanics (4.5%), 195 Mexican hispanics (3.6%), 124 American Indians (2.3%) and 110 others (2.0%). Comparisons of the proportions of minority groups in this sample with the proportions seen among veterans treated for PTSD in other VA programs reveal only modest differences. Specifically, data gathered in a national VA survey (29) show that among Vietnam Era veterans treated for PTSD at VA medical centers during a two-week period in 1990 (N=9,853), 74.9 % were white, 16.1% black, 8.1% hispanic (Puerto Rican and Mexican hispanics were not differentiated in the survey) and 0.8% American Indian. Among Vietnam Era veterans seen for PTSD in VA's Vietnam Veterans Readjustment Counselling Center program (30), a store-front community-based VA program that emphasizes outreach to minorities (N=4,436), 78.3% of those surveyed were white, 12.5% black, 6.9% hispanic and 1.1% American Indian. The proportion of minorities in this sample is thus only slightly greater than the proportion seen in other VA programs.

Veteran Characteristics

As shown in Table 3.1, veterans from different ethnocultural groups differed significantly on several sociodemographic and baseline measures. Whites were older than other veterans. Blacks

were less likely to be married, had lower incomes, and were less likely to be receiving VA compensation payments than other groups. Clinically, blacks had higher levels of alcohol and drug abuse but were less likely to have attempted suicide. It is notable that there were no significant differences between groups in reports of combat exposure, although a greater proportion of Puerto Rican hispanics than whites or Mexican hispanics reported participating in abusive violence. Puerto Rican hispanics reported more PTSD symptoms than either whites or blacks, and both Puerto Rican and Mexican hispanics scored higher than all other groups on psychiatric problems and symptoms. There were no differences among groups in the proportion of veterans reporting medical problems.

Veterans' Identified Needs for Additional Services

Data on veterans' perceived needs are presented in Table 3.2. The most consistent finding is that, as one would expect from their lower incomes, blacks were more likely than other groups to express a need for assistance in the domains of basic resources, finances and employment. Consistent with the data reported above on their clinical status, blacks were also more likely than members of other groups to express a need for assistance with legal problems, alcohol and drug abuse. Puerto Rican hispanics expressed greater need for assistance with interpersonal relationships than whites or blacks, perhaps because a higher proportion were married. In general, whites expressed less need for help with PTSD symptoms than minority groups did.

Service Utilization

Table 3.3 shows the proportion of veterans in each ethnocultural group who had used each of 21 categories of VA and non-VA health services. Since differences in both clinical practice style and in the supply of services exist across sites independently of the ethnocultural status of veterans, ANCOVAs included dichotomous dummy-coded site variables for N-1 sites. By controlling for the influence of sociodemographic characteristics, clinical status, site-specific practice variation and supply effects, the statistical analyses reflect the best estimate possible of the relationship of ethnocultural status to service utilization.

As shown in Table 3.3, blacks made less use of outpatient psychiatric services and psychotropic medications than do other groups, while Puerto Rican hispanics made more use of psychotropic medications, particularly anxiolytics and sleep medications, than other groups. Corresponding to their higher scores on substance abuse measures and self-expressed needs for substance abuse treatment, blacks made greater use of all types of substance abuse treatment than do other groups, with the exception of outpatient treatment for alcoholism. American Indians made greater use of inpatient alcoholism treatment than other groups, with the exception of blacks. There were no differences among groups in the use of specialized PTSD services.

The differential rates of psychiatric and substance abuse service use among various groups appear to cancel each other out, producing no significant differences among whites, blacks, hispanics, or American Indians in their use of all types of psychiatric and substance abuse services. There were also no differences in recent use of any medical services (VA and non-VA); in the use of VA medical services alone; or in overall satisfaction with mental health services received from VA.

Use of PCT Services

Table 3.4 shows that duration of involvement in the PCT program was significantly shorter for blacks than for other groups, and that blacks were more likely than whites and hispanics to terminate treatment within two months of program entry. Corresponding to their greater rate of early termination, blacks had fewer individual sessions than whites and hispanics, and clinicians described their attendance as less regular and their commitment to therapy as less strong.

There were few significant differences between groups on the clinicians' ratings of the content focus of treatment. Clinicians treating blacks, however, reported spending less time on insight-oriented therapy, on deconditioning negative affects and on discussions of war traumas. These activities are usually associated with substantial and prolonged involvement in therapy and may be less prominent among blacks because of their briefer involvement with the PCT program and reportedly lower levels of commitment to therapy. Clinicians reported spending more time with blacks, however, on issues related to substance abuse. Clinicians reported spending more time with Puerto Rican hispanics than with whites, blacks or Mexican hispanics in therapies involving abreacting traumatic affects.

Clinicians' Evaluation of Improvement

Significant differences among ethnocultural groups in the clinicians' ratings of improvement were evident for 4 of 16 measures. Whites were judged to have made more improvement than Mexican hispanics in employment, and more improvement than blacks in social isolation, overall PTSD symptomatology and sleep problems. Subsequent analysis in which clinician race was statistically controlled (see Chapter 4 of this volume) showed no differences in outcomes between racial groups.

Early Termination, Duration of Involvement Among Black Veterans

In view of the results presented above regarding the lesser service utilization and improvement by blacks, an additional series of analyses was conducted to explore possible explanations for these differences. First, duration of involvement was added as a covariate to the analysis of number of sessions received. With duration of involvement controlled, there were no statistical differences between ethnocultural groups in the total number of sessions, in the number of individual sessions, or in the number of

group sessions. The smaller number of treatment sessions received by blacks was thus shown to be a consequence of their briefer involvement in treatment.

Second, both duration of involvement and total number of sessions were added as covariates to models of attendance, commitment, attention to various content areas, and improvement. When these measures of involvement were included as covariates, blacks were still reported to be significantly less regular in their attendance, less committed to treatment, and their treatment focused less on war zone traumas and deconditioning of negative affects than for either whites or Puerto Rican hispanics. Differences in improvement between blacks and whites, however, were no longer significant. Differences between ethnocultural groups in reported improvement, thus, appear to be primarily a function of differences in the duration of involvement in treatment.

In a third series of analyses, we attempted to determine whether the briefer duration of involvement of blacks could be explained by the less frequent use of medications prior to treatment, or by the less intensive focus on war traumas. It seemed plausible that veterans who obtain regular prescriptions for medications are more likely to stay involved in treatment than others, and that those whose war experiences are not addressed as extensively might feel less understood and therefore drop out. With use of medication prior to PCT treatment and attention to war traumas controlled, there were no significant differences between ethnocultural groups in duration of involvement or total number of sessions of treatment received, although differences in regularity of attendance and commitment were still significant. It must be acknowledged that extensive discussion of war experiences may be as much a result of extended treatment as a cause of it, and we cannot, therefore, interpret the meaning of this finding unambiguously. These data, nevertheless, suggest that part of the explanation for the briefer involvement of blacks in treatment is that they were prescribed medication less often, and their treatment focused on war zone trauma less extensively than others.

In a final series of analyses, we explored the possibility that the higher level of substance abuse among blacks might also contribute to their briefer involvement in treatment. Previous analyses demonstrated that substance abuse was associated with briefer involvement in the program, but that it did not fully account for the shorter duration of involvement in the program by blacks. In this series of analyses, we added an interaction term to the analyses to evaluate whether substance abuse was associated with greater attrition from treatment among blacks than among other veterans. These analyses showed that veterans who suffer from substance abuse disorders participated in treatment about one month less than non-substance abusers, but that there was no significant interaction between ethnocultural group membership and substance abuse in predicting duration or other measures of program

involvement.

Differences between blacks and both whites and Puerto Rican hispanics in services received from the PCT program are thus partly attributable to differences in duration of involvement in the program, in the use of prescribed medications, in the amount of time devoted to discussion of war traumas, and in the prevalence of substance abuse problems. These factors do not, however, entirely account for the differences between blacks and others in utilization of Team services.

IV. Discussion

In a previous study, we analyzed data from a national survey of veterans and identified a significant difference in the frequency with which minority veterans used mental health services. As suggested by other studies, blacks and Mexican hispanics were less likely than whites to use professional mental health services. This underutilization, however, was limited to use of non-VA mental health services. It did not characterize utilization of VA services. The current study examined the use of VA services in greater detail.

Using data on over 5,000 veterans assessed in VA's national PCT program, several important differences were found among ethnocultural groups in health service use and in clinical improvement. These differences were most striking for blacks, Puerto Rican hispanics and American Indians.

Blacks were, in several respects, less well off than other groups. They were least likely of all groups to be married, had the lowest incomes and the highest rates of alcohol and drug abuse. Concomitantly, they reported a greater need for help with financial support, employment, and alcohol and drug abuse. Consistent with their expressed needs, they made greater use of substance abuse services. Prospective examination of their use of PCT services showed that blacks were less intensively involved in treatment, and showed less improvement than other groups in several areas.

Puerto Rican hispanics reported the highest levels of PTSD symptoms, and Puerto Rican and Mexican hispanics had the highest levels of general psychiatric symptoms. Puerto Rican hispanics also used psychotropic medications more than other groups, were involved in PCT treatment longer than members of other groups, and spent more time in abreactive therapeutic modalities.

American Indians had significantly higher levels of alcohol problems than all groups except blacks, and correspondingly, reported higher levels of need for alcoholism treatment and used inpatient alcoholism treatment more frequently than any other group except blacks.

It should be reiterated that there were no differences in the ethnocultural proportions of veterans who had made prior use of at least one type of psychiatric or substance abuse service; nor were there any differences in prior use of specialized PTSD services, in overall satisfaction with VA services, or in clinical improvement in the majority of domains.

These findings confirm the general conclusion of our previous study, that ethnocultural minorities do not appear to be at any general or consistent disadvantage in access to, or utilization of, VA health care services. They also demonstrate that, although differences between whites and minorities were not found in overall use of services, there are clear differences among ethnocultural minority groups in use of specific mental health services. Blacks, in particular, appear to be less involved in treatment than either whites or Puerto Rican hispanics.

These differences between ethnocultural groups in specific service utilization and clinical improvement may be explained in three ways. First, the differences may reflect epidemiologic differences in the type and/or severity of the disorders for which they seek help. Second, differences in service use and outcome may reflect differences in receptiveness or responsiveness to the treatments offered, whether ethnoculturally or socioeconomically determined. Finally, there may be differences among groups that are attributable to the way providers treat them, either by providing different amounts or types of services, or by providing a different quality of services. It remains for us to draw on the data available here, and on other published studies, to evaluate the role of these explanations in generating the minority group utilization patterns observed above.

Both the greater proportion of unmarried black veterans and their substantially lower incomes reflect national trends that are well demonstrated in studies such as the NVVRS (17). Higher rates of alcohol and drug use among blacks, although reported from several studies conducted in urban centers (31-32), have not been confirmed in national surveys such as the NVVRS (17) or the Epidemiologic Catchment Area (ECA) study (33). We can not therefore determine whether the high rate of substance abuse among black veterans in the VA sample reflects a greater rate of substance abuse among black veterans generally, or whether it reflects a tendency for black veterans suffering from substance abuse to seek help, or more specifically, to seek help from VA. The lower rate of utilization of medications among blacks probably reflects both a general reluctance among blacks to take medication (5) or a reluctance among clinicians to prescribe medications to veterans who a history of substance abuse (21).

It is more difficult to explain the briefer involvement of blacks and other differences in their participation in the PCT program. Several interpretations are possible, some of which

receive partial support from our analyses. First, blacks are less likely to use medications, less likely to spend time discussing their war experiences in treatment, and are more likely to have substance abuse problems than other veterans. We have shown, above, that these factors partially explain their briefer involvement in PCT treatment. Second, important service needs of black veterans in the area of financial support and employment may not be adequately met by the PCT program because of its central focus on mental health services. Blacks may terminate earlier from the program because it meets these needs incompletely. Third, since the majority of VA mental health professionals are white, it is also possible that black veterans find it more difficult to sustain involvement in therapy with clinicians who are white, or, alternatively, that white clinicians are less successful at engaging black veterans in treatment. Although differential rates of service utilization have been identified between blacks and whites in some, but not all, studies of mental health care (8, 34-37) and in many studies of physical health care (38-39), the relationship of these findings to racial differences between patient and clinician have been addressed in only one large clinical study. In that study (37) clients with ethnically matched clinicians were less likely than clients with ethnically unmatched clinicians to drop-out after one session, and received a greater number of treatment sessions, although there was no relationship between ethnic matching and clinical outcome. However, among blacks, ethnic matching did not effect dropping out after one session, although it was associated with having a greater number of sessions. It is notable, however, that in a separate study of veterans treated by two PCTS that had both white and black clinicians, we found no differences in duration of involvement or number of sessions related to the racial match of clinicians and patients (see Chapter 5 of this report).

Like others who have found evidence of relative underutilization of health care services among blacks, even after adjustment for socioeconomic and clinical factors (40), we have no ready explanation for our findings. In a recent overview of the situation of black Americans, Princeton theologian Cornel West echoed the thoughts of many other scholars and social scientists in suggesting that centuries of racial oppression have generated a pervasive nihilism, pessimism and hopelessness among black Americans (41). It is possible that this nihilism, or some related phenomenon, unmeasured in our study, may account for the lesser utilization among blacks of available mental health services.

Findings of increased symptomatology and greater use of abreactive therapies among hispanics, especially Puerto Rican hispanics, are consistent with an extended series of epidemiologic studies that have shown that: 1) Puerto Rican hispanics report higher frequencies of psychiatric symptoms than other groups; 2) among Puerto Ricans living on the mainland, reporting psychological symptoms is relatively socially desirable; 3) increased symptom

reporting among Puerto Ricans reflects an acquiescent response style; and 4) among Puerto Ricans, somatization is a socially conventional way of expressing psychological distress (42). Our observations that Puerto Rican veterans are prescribed psychotropic medications more frequently than other groups, and have more sustained involvement in treatment, are also consistent with findings of other researchers that Puerto Ricans are more likely to remain in treatment when they are prescribed medications (43); and that they have a greater affinity for medical services than Mexican hispanics (44).

The high level of alcohol-related problems and inpatient alcohol service use observed among American Indian veterans is consistent with epidemiologic data describing high levels of alcoholism in some, although not all, American Indian tribes (45, 46).

In summary, this study of veterans seeking treatment for PTSD has identified several differences among ethnocultural groups in service utilization and clinical improvement. Most of these differences are explained by epidemiologic and cultural factors that exist independently of service system characteristics, and are similar to findings reported in other studies. The evidence of less involvement in treatment among blacks, however, is not fully explained by any of the factors we have examined and calls for additional study.

References

1. Marmor TR, Mashaw JL and Harvey PL (1990) America's Misunderstood Welfare State, New York, Basic Books.
2. Adkins R (1967) Medical Care for Veterans, US Government Printing Office, Washington, DC, 1967.
3. Skocpol T (1992) Protecting Soldiers and Mothers: The Political Origins of Social Policy in the United States, Cambridge, Mass. Harvard University press.
4. Berryman SE (1988) Who serves? The Persistent Myth of the Underclass Army. Boulder CO: Westview Press.
5. Lefley HP (1990) Culture and Chronic Mental Illness, Hospital and Community Psychiatry 41: 277-286.
6. Snowden LR and Cheung FK (1990) Use of Inpatient Mental Health Services by Members of Ethnic Minority Groups. American Psychologist 45: 347-355.
7. Sue S (1977) Community Mental Health Services to Minority Groups. American Psychologist 32: 616-624
8. Acosta FX (1980) Self-described reasons for premature termination of psychotherapy by Mexican American, black American and Anglo-American patients. Psychological Reports, 47:435-443
9. Terry W (1984) Bloods: An Oral History of the Vietnam war by Black Veterans, New York, Random House.
10. Parson ER (1985) Ethnicity and Traumatic Stress: The Intersecting Point in Psychotherapy, in CR Figley (Ed) Trauma and Its Wake, Volume I. New York, Brunner/Mazel.
11. Parson ER (1985) The Black Vietnam Veteran: His Representational World, in WE Kelley (Ed.) Post-Traumatic Stress Disorder and the War Veteran Patient, New York, Brunner/Mazel.
12. Silver SM and Wilson JP (1988) Native American Healing and Purification Rituals for War Stress, in JM Wilson, Z Harel and B Kahana (Eds) Human Adaptation to Extreme Stress: From the Holocaust to Vietnam, New York, Plenum.
13. Myths and Realities: A Study of Attitudes Towards Vietnam Era Veterans (1980) A Report submitted by the Veterans Administration to the Committee on Veterans Affairs, United States Senate, Washington, DC.

14. Marsella AJ, Friedman MJ and Spain EH (1993) Ethnocultural aspects of PTSD: An overview of issues, research and directions, in JM Oldham, A Tasman and M Riba (Eds) American Psychiatric Press Review of Psychiatry, Washington, DC, American Psychiatric Press.
15. Westermeyer J (1989) Cross-cultural care for PTSD: Research, training and service needs for the future. *Journal of Traumatic Stress* 2:515-536.
16. Lawson W (1986) Racial and Ethnic Factors in Psychiatric Research, *Hospital and Community Psychiatry* 37: 50-54.
17. Rosenheck R and Fontana A (1993) Utilization of Mental Health Services Among Minority Veterans of the Vietnam Era (see Chapter 2 of this volume).
18. Kulka RA, Schlenger WE, Fairbank JA, Hough RL, Jordan BK, Marmar, CR and Weiss DA (1989) Trauma and the Vietnam War Generation: Report of Findings from the National Vietnam Veterans Readjustment Study. New York, Brunner/Mazel.
19. Kulka RA, Schlenger WE, Fairbank JA, Hough RL, Jordan BK, Marmar, CR and Weiss DA (1990) The National Vietnam Veterans Readjustment Study: Tables of Findings and Technical Appendices. New York, Brunner/Mazel.
20. Kleinman A (1988) Rethinking Psychiatry, New York, The Free Press.
21. Fontana A, Rosenheck R, and Spencer H. (1993) The Long Journey Home III: The Third Progress Report on the Department of Veterans Affairs PTSD Programs. Northeast Program Evaluation Center, Evaluation Division of the National Center for PTSD, Department of Veterans Affairs Medical Center, West Haven, Connecticut.
22. Fontana A, Rosenheck R, and Spencer H. (1990) The Long Journey Home: The First Progress Report on the Department of Veterans Affairs PTSD Clinical Teams Program. Northeast Program Evaluation Center, Evaluation Division of the National Center for PTSD, Department of Veterans Affairs Medical Center, West Haven, Connecticut.
23. Laufer RS, Yager T, Frey-Wouters E, and Donnellan J (1981) Legacies of Vietnam. Vol. III. Post-War Trauma: Social and Psychological Problems of Vietnam Veterans and Their Peers; House Committee Print No. 14, U.S. Government Printing Office, Washington, D.C.
24. Spitzer RL, Williams JBW (1985) Structured clinical interview for diagnosis. New York, New York State Psychiatric Institute

25. McLellan AT, Luborsky L, Cacciola J, Griffith J, Evans F, Barr HL, and O'Brien CP (1985) New data from the Addiction Severity Index: Reliability and validity in three centers. *Journal of Nervous and Mental Disease* 173:412-423.

26. Ewing JA (1984) Detecting alcoholism: The CAGE questionnaire. *JAMA* 252: 1905-1907.

27. Vernez G, Burnam MA, McGlynn EA, Trude S and Mittman BS (1988) Review of California's Program for the Homeless Mentally Disabled. Santa Monica, CA, Rand Corporation.

28. Robins LN, Helzer JE, Croughan, et al (1981) The National Institute of Mental Health Diagnostic Interview Schedule. *Archives of General Psychiatry* 38: 381-389.

29. Ronis D, Bates EW and Wolff NW. 1992 Survey of Outpatient Mental Health and Readjustment Counseling Services; Analyses of Diagnoses and Problems. Ann Arbor, MI, VA Great Lakes HSR&D Field Program.

30. Blank AS Jr (1993) Vet Centers: A New Paradigm in Delivery of Services for Victims and Survivors of Traumatic Stress, in Wilson JS and Raphael B (Eds) International Handbook of Traumatic Stress Syndromes, New York, Plenum.

31. Williams D (1986) The Epidemiology of Mental Illness in Afro-Americans, *Hospital and Community Psychiatry*, 37:42-49.

32. Sutocky JW, Shultz JM and Kizer KW (1993) Alcohol-Related Mortality in California. 1980-1989, *American Journal of Public Health*, 83: 817-823.

33. Robins LN and Regier DA (1991) Psychiatric Disorders in America: The Epidemiologic Catchment Area Study, New York, The Free Press.

34. Solomon P (1988) Racial Factors in Mental Health Service Utilization, *Psychosocial Rehabilitation Journal* 11: 3-12.

35. Mollica RF, Blum JD and Redlich F (1980) Equity and the Psychiatric care of the Black Patient, 1950-1975, *Journal of Nervous and mental Disease* 168: 279-286

36. Blendon RJ, Aiken LH, Freeman HE and Corey CR (1989) Access to Medical Care for Black and White Americans, *JAMA* 261:278-281.

37. Sue S (1991) Community Mental Health Services for Ethnic Minority Groups: A Test of the Cultural Responsiveness Hypothesis, *American Psychologist* 59: 533-540

38. Escarce JJ, Epstein KR, Colby DC, Schawrtz JS (1993) Racial Differences in the elderly's use of medical procedures and diagnostic tests. *Am J Public Health* 83:948-954.

39. Cowies MR, Fahrenbruch CE, Cobb LE, Hallstrom AP (1993) Out-of-hospital cardiac arrest: racial differences in outcome in Seattle. *Am J Public Health* 83:948-954.

40. Bergner L (1993) Race, Health and Health Services (1993) *Am J Public Health* 83:948-954.

41. West C (1993) *Race Matters*, Boston, Beacon Press.

42. Guarnaccia PJ, Good BJ and Kleinman A (1990) A critical review of epidemiological studies of Puerto Rican Mental Health. *American Journal of Psychiatry* 147: 1449-1456.

43. Dworkin RJ and Adams GL (1987) Retention of Hispanics in Public Sector Mental Health Services, *Community Mental Health Journal* 23:204-216.

44. Schur CL, Bernstein AB and Berk ML (1987) The Importance of Distinguishing Hispanic Subpopulations in the Use of Medical Care, *Medical Care* 25: 627-641.

45. Fleming CM (1992) American Indians and Alaskan Natives: Changing Societies Past and Present, in MA Orlandi (Ed.) *Cultural Competence for Evaluators: A Guide for Alcohol and Drug Abuse Prevention Practitioners Working with Ethnic/ Racial Communities*. Rockville, Md., U.S. Department of Health and Human Services.

46. US Department of Health and Human Services (1987) *Alcohol and Health*. Washington DC, US Government Printing Office.

Table 3.1. Predictors of service use, by ethnocultural group (53 PCI sites).

		White-1 (N=3,879)	Black-2 (N=918)	Puerto Rican (N=269)	Mexican Hispanic-3 (N=195)	American-4 (N=124)	Indian-5 (N=124)	Other-6 (N=110)	F	Significant differences (1)
Socio-demographic characteristics										
Age	46.27	43.82	43.63	45.50	44.00	51.35	30.7 e	1>2,3,5; 6>1,2,3,4,5		
Married	0.50	0.30	0.59	0.54	0.43	0.55	30.1 e	2<1,3,4,6; 3>1,5		
Working	0.56	0.47	0.47	0.53	0.46	0.32	3.4 c			
Personal Income	\$1,179	\$755	\$1,053	\$947	\$901	\$1,297	35.2 e	2>1,3,6		
VA Compensation	0.58	0.52	0.63	0.55	0.55	0.59	3.5 c	2>1,3		
War zone stress										
Combat exposure	10.52	10.73	10.91	10.55	10.58	10.50	1.6			
Abusive violence in VN	0.29	0.31	0.38	0.21	0.37	0.31	4.2 d	3>1,4; 5>4		
Illness characteristics										
PTSD (SCID Sum)	1.51	1.52	1.66	1.59	1.60	1.67	8.2 e	3>1,2,6		
Psychiatric Problems (AS1)	0.56	0.57	0.63	0.61	0.54	0.53	7.6 e	3>1,2,5,6; 4>1,2,5,6		
Alcoholism (CAGE)	1.22	1.66	1.07	1.12	1.53	0.84	15.3 e	2>1,3,4,6; 5>6		
Drug Abuse (DIS)	0.46	0.88	0.49	0.55	0.52	0.53	27.2 e	2>1,3,4,5,6		
Ever Attempted Suicide	0.38	0.32	0.48	0.38	0.47	0.35	5.6 e	2>1,3,5; 3>1		
Medical Problem	0.53	0.56	0.49	0.51	0.58	0.65	2.3 b			

(1) Statistical comparisons are based on ANOVAs with Tukey multiple range test for paired comparisons (p<.05)

Key:

- a - p < .10
- b - p < .05
- c - p < .01
- d - p < .001
- e - p < .0001

Table 3.2. Clinical needs as reported by veterans assessed for treatment by VA's PTSD Clinical Teams program (53 sites)(1).

		White-1 (N=3,879)	Black-2 (N=918)	Puerto Rican (N=269)	Hispanic-3 (N=195)	Mexican Hispanic-4 (N=195)	American Indian-5 (N=124)	Other-6 (N=110)	F	p Tukey p<.05
Community/Social Adjustment										
Basic Needs (food, shelter, clothing)	32.5%	55.2%	35.5%	35.6%	42.0%	37.7%	36.5%	2>1,3,4,5,6		
Financial Support	51.3%	73.4%	57.4%	58.2%	59.7%	55.7%	38.6%	2>1,3,4,5,6		
Employment	42.6%	58.6%	43.4%	49.5%	46.2%	34.9%	20.0%	2>1,3,6		
Legal problems	11.7%	14.1%	7.9%	11.9%	15.1%	10.4%	2.0%	2>3		
Interpersonal relationships	54.6%	53.6%	64.5%	53.6%	54.6%	50.9%	2.4%	b	3>1,2	
Daily social activities	56.7%	58.3%	64.5%	53.1%	59.7%	48.1%	2.6%	b	3>6	
Health Care Problems										
Alcohol abuse	22.7%	32.0%	20.2%	17.5%	35.3%	15.1%	18.7%	e	2>1,3,4,6; 5>1,3,4,6	
Drug abuse	10.0%	25.6%	11.2%	14.9%	15.1%	17.9%	50.3%	e	2>1,3,4,5; 6>1	
War-related stress	92.0%	94.5%	93.8%	96.9%	93.3%	92.5%	3.2%	c	1<2,4	
Reliving experiences	64.0%	88.5%	92.1%	90.2%	89.1%	81.1%	7.8%	e	3>1,6; 2>1	
Numbing of emotions	82.3%	84.3%	81.0%	82.4%	84.0%	68.8%	4.5%	d	6>1,2,3,4,5	
Violent impulses	66.6%	71.3%	76.4%	70.1%	63.9%	74.5%	5.1%	e	1<3,2	
Sleep problems	82.4%	88.2%	88.8%	91.7%	89.9%	81.1%	9.5%	e	1<2,3,4	
Another psychiatric condition	27.3%	25.7%	18.6%	31.4%	30.5%	19.8%	3.2%	c	3>1,4	
Medical condition	41.9%	45.1%	43.0%	45.4%	48.7%	47.2%	1.6			

(1) Statistical comparisons are based on ANOVAs with Tukey multiple range tests ($p<.05$) controlling for the influence of age, combat exposure, marital status, current employment, medical problems, PTSD symptoms, psychiatric problems, alcohol abuse, drug abuse, income, and site-specific practice patterns.

Key:

- a - $p < .10$
- b - $p < .05$
- c - $p < .01$
- d - $p < .001$
- e - $p < .0001$

Table 3.3. Past use of services by veterans assessed for treatment by VA's PTSD Clinical Teams program (53 sites)(1).

	White-1 (N=3,879)	Black-2 (N=918)	Rican (N=249)	Mexican Hispanic-3 (N=95)	Hispanic-4 (N=95)	American Indian-5 (N=124)	Other-6 (N=110)	F	p	Significant Differences Tukey p<.05
Psychiatric Treatment										
Psychiatric Inpatient	51.7%	49.9%	57.0%	47.7%	52.1%	43.4%	1.6			
Psychiatric Inpatient (VA)	45.3%	43.8%	52.1%	43.8%	47.1%	37.7%	0.9			
Psychiatric Outpt. (VA or non-VA)	69.3%	57.9%	74.4%	74.2%	62.2%	62.3%	4.8 d	2<1,3,4		
Psychiatric Outpt. (VA)	69.3%	57.9%	74.3%	74.2%	62.2%	62.3%	4.7 e	2<1,3,4		
Any Psychiatric Treatment (IP or OP)	77.8%	69.2%	81.8%	77.8%	70.6%	67.9%	4.6 d	2<1,3,4		
Any VA Psychiatric Treatment (IP or Specialized PTSD Treatment	76.2%	66.8%	80.2%	77.3%	68.9%	67.0%	4.9 d	2<1,3,4		
Psychotropic Medications	33.9%	29.7%	28.9%	38.7%	36.1%	35.8%	0.9			
Anxiolytics	57.3%	47.9%	69.0%	60.6%	52.9%	47.2%	4.6 d	2<1,3,4; 3>1,2,5,6		
Anti-depressants	26.3%	18.0%	49.2%	26.8%	19.3%	17.0%	5.2 e	3>1,2,4,5,6; 1>2		
Sleep Medications	40.4%	30.2%	43.6%	42.3%	37.0%	23.6%	4.4 d	2<1,3,4; 6<1,3,4		
Substance Abuse										
Alcohol Inpatient	36.9%	43.4%	25.2%	29.4%	53.8%	18.9%	2.7 b	2>1,3,4,6; 5>1,3,4,6; 1>3,6		
Alcohol Outpatient	39.6%	42.8%	27.3%	34.0%	48.7%	21.7%	3.3 c	3<1,2,5; 6<1,2,5; 4<5		
Drug Inpatient	14.8%	34.7%	16.1%	15.5%	18.5%	20.8%	16.4 e	2<1,3,4,5,6		
Drug Outpatient	12.8%	30.8%	13.6%	17.5%	14.3%	18.9%	13.7 e	2<1,3,4,5,6		
Substance Abuse Inpatient (A or D)	41.1%	57.1%	30.6%	32.5%	56.3%	29.2%	4.0 c	2>1,3,4,6; 5>1,3,4,6; 1>3,6		
Substance Abuse Outpatient (A or D)	53.3%	31.4%	38.1%	51.3%	27.4%	2.8 b	2>1,3,4,6; 3<1,2,5; 6<1,2,5			
Any Substance Abuse (IP or OP)	49.9%	64.7%	38.0%	42.8%	64.7%	34.0%	4.4 d	2>1,3,4,6; 5>1,3,4,6; 3<1,2,5; 6<1,2,5		
Summary: Mental Health Services										
Any Psych. or Substance Abuse Trt.	89.0%	89.1%	89.7%	84.0%	85.7%	71.7%	6.4 e	6<1,2,3,4,5		

Table 3.3 (continued). Past use of services by veterans assessed for treatment by VA's
PTSD Clinical Teams program (53 sites)(1).

		Rican	Mexican	American	Indian ^a	Other ^b	Significant Differences		
	White ^c (N=3,870)	Black ^d (N=918)	Hispanic ^e (N=249)	Hispanic ^f (N=195)	Hispanic ^g (N=124)	Other ^h (N=10)	F	p	Tukey p<.05
Medical Treatment									
Medical treatment	42.1%	43.3%	38.4%	42.3%	46.2%	44.3%	1.1		
Medical treatment (VA)	33.2%	36.5%	35.1%	35.6%	38.7%	34.0%	1.5		
Satisfaction With VA Services									
	1.76	1.74	1.85	1.79	1.76	1.73	0.2		

(1) Statistical comparisons are based on ANCOVAs with Tukey multiple range tests (p<.05) controlling for the influence of age, combat exposure, marital status, current employment, medical problems, PTSD symptoms, psychiatric problems, alcohol abuse, drug abuse, income, and site-specific practice patterns.

Key:

- a - p< .10
- b - p< .05
- c - p< .01
- d - p< .001
- e - p< .0001

Table 3-4. Use of PCI Services by ethnocultural groups.

	White-1 (N=3,879)	Black-2 (N=918)	Rican (N=269)	Hispanic-3 (N=195)	Mexican-4 (N=195)	American Indian-5 (N=124)	Other-6 (N=110)	F	P	Significant Differences Tukey p<.05
Participation in Treatment										
Duration of Involvement (months)	5.45	4.58	7.66	6.16	5.27	5.35	1.84 a	2<1,3,4; 3>1,2,5		
Terminated Before 2 Months	0.35	0.41	0.24	0.26	0.37	0.38	2.59 b	1>3,4; 2>1,3,4		
Total Sessions	23.00	17.99	21.78	20.79	24.03	22.87	3.31 c	1>2		
Individual Sessions	11.11	8.42	11.65	11.63	10.57	9.16	6.86 e	2<1,3,4		
Group Sessions	11.80	9.73	9.44	9.04	13.63	13.76	1.23			
Attendance	1.63	1.37	1.59	1.46	1.55	1.67	6.61 e	2<1,3,6		
Commitment	2.55	2.18	2.47	2.44	2.48	2.51	8.3 e	2<1,2,4		
Clinical Time Committed To (3):										
Current Social Adjustment	1.79	1.79	1.63	1.86	1.71	1.59	1.60			
Vocational Counseling	0.11	0.15	0.04	0.05	0.14	0.04	0.72			
Social Skills Training	0.62	0.61	0.49	0.51	0.64	0.36	0.24			
Crisis Intervention	0.31	0.31	0.20	0.29	0.29	0.33	1.82			
Benefits Counseling	0.22	0.22	0.14	0.16	0.18	0.12	0.33			
Working Towards Psychological Insight	1.42	0.97	1.28	1.06	1.13	1.14	2.81 b	2<1,3		
Directive Therapy	0.85	0.89	0.90	0.84	0.92	1.18	5.10 e	6>1,2,4		
Conditioning Negative Affects	0.49	0.38	0.52	0.56	0.55	0.39	3.33 e	2<1,4		
Abreacting Negative Trauma-Related Affects										
Discussing War Traumas	0.74	0.66	1.14	0.69	0.71	0.84	2.75 b	3>1,2,4,5		
Substance Abuse Treatment	1.98	1.09	1.24	1.36	1.09	1.40	3.95 c	2<1,4,6		
Physical Illness	0.38	0.53	0.27	0.20	0.47	0.47	2.09 a	2>1,3,4; 4<1,5		

(1) Statistical comparisons are based on ANCOVAs with Tukey multiple range tests ($p<.05$) controlling for the influence of age, combat exposure, marital status, current employment, medical problems, PTSD symptoms, psychiatric problems, alcohol abuse, drug abuse, income, and site-specific practice patterns.

Key:

- a - $p < .10$
- b - $p < .05$
- c - $p < .01$
- d - $p < .001$
- e - $p < .0001$

Chapter 4 -

**Racial Factors in the Outpatient Treatment of Veterans Suffering
from Posttraumatic Stress Disorder**

by

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Abstract

Objective: This study explores the effect of veteran race, and of the match between veteran and clinician race on the process and outcome of treatment for war-related PTSD.

Methods: As part of the national evaluation of the Department of Veterans Affairs PTSD Clinical Teams program, admission assessment data were obtained on white and black male veterans ($N=4,726$), and on the race and other characteristics of their primary clinicians ($N=315$). Measures of service delivery and treatment emphasis were obtained 2, 4, 8 and 12 months after program entry, along with clinician improvement ratings.

Results: After controlling for other factors using multivariate analysis, program participation among black veterans was significantly lower than that of white veterans on 13 of 24 measures, but no differences were noted on clinician improvement ratings. The specific pairing of white clinicians with black veterans was associated with lower program participation on 6 of 24 measures, and with lower improvement ratings on 5 of 16 measures. In addition, when treated by either black or white clinicians, black veterans had poorer attendance than white veterans, seemed less committed to treatment, received more treatment for substance abuse and were less likely to be prescribed antidepressant medications.

Conclusions: On some measures, the pairing of black veterans with white clinicians is associated with reduced participation and improvement in treatment for PTSD. On others, black veterans receive less intensive services regardless of the race of the clinician.

I. Background

Empirical studies conducted in recent decades have suggested that ethnic minorities are less likely to use outpatient mental health services than whites (1-3); receive fewer mental health services (4-5); tend to be treated by less well-trained professionals (1,4); and derive less benefit from treatment (7-8). Although these findings have not been consistently replicated (9-12), they have raised persistent doubts about the relative accessibility and effectiveness of mental health services for ethnic minorities, and especially for black Americans.

The reasons for these racial differences remain unclear but may reflect ethnoculturally based attitudes and behaviors of patients, clinicians (most of whom are white) or, as is most likely, both. In a large study involving nearly 14,000 users of Los Angeles county mental health services, blacks were more likely than other ethnocultural groups to contact the mental health system, but they were also more likely to drop out after one session, attend fewer sessions, and show less clinical improvement than other clients (8). Participation in treatment, but not clinical outcome, was somewhat improved when services were provided by black clinicians.

The National Vietnam Veterans Readjustment Study (NVVRS), a major epidemiological study conducted in 1986-87, demonstrated that, a full decade after the end of the Vietnam war, 22% of black Vietnam veterans suffered from posttraumatic stress disorder as compared to only 14% of white veterans (13). Although the NVVRS offered no explanation for these differences, they are consistent with the many accounts of the exceptionally harsh experiences of minority troops who served in Vietnam (14-15). As a result of the NVVRS and other studies (15), considerable concern has been expressed that effective treatment for PTSD be readily accessible to black Vietnam veterans (16).

Previous studies of the treatment of blacks in VA have demonstrated that, after controlling for economic and health status factors that affect health service utilization, black veterans are more likely than whites to use VA services (17) and, more specifically, that black Vietnam era veterans are no less likely to chose VA over non-VA mental health services (18). No published study, however, has systematically examined the influence of veteran and clinician race on participation and outcome in specialized PTSD treatment.

The current study, based on data from almost 5,000 non-hispanic black and white male veterans treated in VA's PTSD Clinical Teams (PCT) Program, sought to identify differences in the treatment received by blacks and whites in three areas: 1) involvement in treatment (duration of treatment, number of sessions, regular attendance, and commitment to change), 2)

clinical service emphases (e.g. skills training, crisis intervention, substance abuse treatment, insight oriented therapy); and 3) clinicians' improvement ratings in multiple domains. Beyond determining whether racial patterns observed in other mental health systems are also observable among black veterans seeking help for PTSD from VA, we sought to determine whether such differences are specifically attributable: 1) to the pairing of black veterans with white clinicians; or 2) to being black, regardless of the race of the clinician.

II. Methods

In 1988, Congress provided VA with special funds to establish a network of specialty mental health clinics for the treatment of war-related PTSD. Each PCT was to include three clinicians, a psychiatrist, a psychologist and a social worker, nurse and/or other qualified professional. Specific treatments provided by PCTs were not centrally mandated, but were to be determined by the clinical needs and skills at each site.

Data Collection

As part of a national evaluation of the implementation of the PCT program, approximately the first 100 veterans seen at each of 53 sites representing every region of the country were assessed with the War Stress Interview (19). The WSI was administered by program clinicians to formally assess sociodemographic characteristics, combat exposure, clinical status, and current social adjustment at the time of program entry.

The continued participation of veterans in PCT treatment was monitored for one year using a structured clinical summary completed by PCT clinicians 2, 4, 8 and 12 months after each veteran entered treatment. This summary allowed determination of: 1) the duration of veterans' participation in treatment for up to one year; 2) the number of treatment sessions; 3) the clinicians' assessment of regularity of attendance and commitment to treatment during the first two months of treatment; 4) clinical emphases in the treatment; and 5) the clinicians' rating of improvement in 15 domains at the time of last contact.

A post hoc telephone survey was conducted to identify the gender, race, professional training, and veteran status of each veteran's primary clinician. Only non-hispanic black (N=910; 17%) and white (N=3,816; 71%) male veterans were included in this study. Hispanic and other veterans (N=674; 12%) were excluded.

Measures

Age, race, marital status, education, employment, income and VA disability status were determined by veterans' reports. Exposure to combat was measured by the Revised Combat Scale (20). PTSD symptoms were measured as the mean of responses to the Structured Clinical Interview for Diagnosis criteria for PTSD (21), while

general psychiatric problems were assessed using the psychiatric subscale of the Addiction Severity Index (ASI) (22). Alcohol abuse was assessed using the four "CAGE" items (23), and drug abuse with selected items from the Diagnostic Interview Schedule (DIS) (24-25). The presence of medical problems was evaluated by asking the veteran a single question as to whether he suffered from a serious medical problem.

The number of individual, group and total treatment sessions, and the date of last contact with the PCT were recorded on the periodic clinical progress summaries. While these basic measures were obtained on virtually the entire sample, additional indicators of involvement, treatment emphases and improvement, were only collected on veterans who had more than one session.

General patterns of attendance were assessed by the primary clinician after two months using a three-level question (1=attended only once or twice; 2= attendance has been continuing but irregular; 3=attendance is quite regular). Commitment to treatment was also assessed by each clinician after two months, using a five point scale (0=not at all committed; 2= slightly committed; 2=moderately committed; 3= highly committed; 4=maximally committed).

Content emphasis in treatment was addressed through a series of questions that asked, overall, the proportion of clinical time that was spent on each of 12 clinical modalities (listed in Table 4.3). Responses were coded 0=no time; 1=a little time (less than 10%); 2=some time (between 10% and 50%) and 3=a lot of time (more than 50%). Since there could be more than one progress summary per veteran, data on therapeutic content focus were averaged across all observations, for each veteran. An additional series of questions concerned prescribed medications.

Clinical improvement since the initiation of contact with the program was rated by each veteran's primary clinician and documented for 15 separate domains (listed in the last panel of table 3) using a 5-point scale: 0=substantial deterioration; 1=some deterioration; 2=no change; 3=some improvement; 4=substantial improvement. Ratings were only made for veterans who were identified as having a problem in the domain under consideration. The improvement rating used for this study was the last one reported, for each veteran. Unfortunately, data on the reliability and validity of these measures are not available.

Analyses

Data analysis proceeded in three stages. First, one-way analysis of variance was used to compare black and white veterans on sociodemographic and clinical characteristics.

Second, analysis of covariance (ANCOVA) was used to evaluate overall differences between black and white veterans in program

participation and clinician-rated improvement. Since differences between racial groups are likely to be influenced by factors other than race, statistical adjustment was made for baseline veteran characteristics (age, marital status, combat exposure, PTSD, psychiatric problems, substance abuse, income, service-connected status); clinician characteristics (gender, race, professional background, and veteran status); and variations in clinical practice across sites. The effect of site was modeled with dummy codes for each site.

Third, of one-way analyses of covariance (ANCOVAs) were used to identify differences in program participation and improvement among the four possible clinician-veteran racial pairings (1=white clinician-black veteran; 2=white clinician-white veteran; 3=black clinician-black veteran; and 4=black clinician-white veteran). Tukey multiple-range tests ($p < .05$) were used to compare the significance of differences between each of the four clinician-veteran pairings.

Results of the Tukey tests were used to identify evidence of, what we have termed, problematic racial pairings. A problematic racial pairing occurs when receipt of a significantly lower level of services can be attributed to racial heterogeneity in the clinician-veteran dyad. In theory, problematic pairings can occur when either white clinicians treat black veterans, or when black clinicians treat white veterans. We used two criteria to identify problematic racial pairings. First, treatment provided through a heterogeneous racial pair must be significantly different from treatment provided through both types of homogeneous pairings (e.g., services provided by white clinicians to black veterans are significantly different than services provided by white clinicians to white veterans and black clinicians to black veterans: pairing group 1<2,3). Second, the services or outcomes observed for the heterogeneous clinician-veteran pair must be less desirable than those observed among homogeneous pairs. It should be emphasized that these criteria for problematic racial pairings entail no judgment as to the reasons for their occurrence.

III. Results

Black veterans were younger, poorer, less likely to be married, and less likely to be receiving VA compensation than white veterans (Table 4.1). Blacks also reported more extensive combat exposure than whites, but no significant differences were observed for PTSD symptoms or psychiatric problems. Black veterans scored substantially higher on alcohol and drug abuse indices.

Altogether, 315 clinicians provided treatment to the veterans in this study. Eighteen (5.7%) were black. Table 4.2 compares clinicians who treated black veterans with clinicians who treated white veterans on race, gender, professional background, and veteran status (including Vietnam service). Black veterans were

significantly more likely than white veterans to be treated by clinicians who were black, female, and who were nonveterans, although the differences were small in magnitude.

Comparison of black and white veterans

ANCOVAs reported in table 3 show that, after adjusting for veteran and clinician characteristics, there were significant differences between black and white veterans on 14 measures of participation, but on none of the improvement ratings. On six of eight involvement measures, black veterans participated less intensively than whites. A greater proportion of blacks terminated within three months of beginning treatment and, on average, blacks were seen for 19% fewer months, had 32% fewer sessions, and scored almost 20% lower on clinicians' attendance and commitment ratings.

The two middle panels of Table 4.3 show that, compared to whites, treatment sessions for blacks involved less discussion of war trauma, less insight-oriented psychotherapy, less time devoted to abreactive therapy and to deconditioning of negative affects, and less use of psychotropic medication. Moreover, even after controlling for severity of substance abuse, treatment of blacks involved greater emphasis on substance abuse treatment.

The bottom section of Table 4.3 shows that there were no significant differences between blacks and whites on any of the clinician improvement ratings. Thus, although black veterans participated less intensively in services than whites, their improvement ratings were no worse.

Clinician-veteran racial pairings

Mean values for each of the four clinician-veteran racial pairings are presented in Table 4.4. No problematic racial pairings were observed for black clinicians treating white veterans (4<2,3). Problematic racial pairings involving white clinicians and black veterans (1<2,3) were observed on 10 measures : 1) four of the eight measures of the intensity of involvement (duration of treatment, total sessions, individual sessions and clinicians' ratings of commitment to treatment); 2) two of twelve measures of treatment emphasis (insight-oriented therapy and deconditioning negative affects); 3) and four improvement measures (violent behavior, numbing symptoms, sleep problems, and reliving symptoms).

Addition of treatment involvement measures (measures listed in the first panel in table 4) as covariates in the analysis of treatment emphasis (measures listed in the second and third panels) did not alter the results reported above (results of ANCOVAs available on request). When measures of both treatment involvement and treatment emphasis were added as covariates to the analyses of improvement, two problematic racial pairings remained statistically significant (reliving and numbing symptoms).

Tukey tests also showed that when treated by either black or

white clinicians, black veterans were rated by their clinicians as having poorer attendance than white veterans, seemed less committed to treatment, received more treatment for substance abuse and were less likely to be prescribed antidepressant medications.

IV. Discussion

Summary of findings

Race appears to be a significant factor in the outpatient treatment of PTSD. In this study, black veterans were found to receive less treatment, on several measures, than white veterans, but to receive greater emphasis in their treatment on substance abuse. Examination of clinician-veteran racial pairings suggested that black-white differences were at least partially attributable to the problematic racial pairing of white clinicians with black veterans. Evidence of such problematic racial pairing was also observed on several clinician ratings, with white clinicians reporting greater improvement by white veterans than by black veterans.

Limitations and strengths of data and methods

Before further considering the meaning and importance of these findings, both weaknesses and strengths of the data presented must be addressed. First, we must acknowledge that the validity and reliability of the measures used to assess the process and outcome of treatment have, unfortunately, not been tested. However, since imprecision in these measures would reduce the likelihood of finding significant interracial differences, the lack of such validation would have been more of a threat to the findings if no differences had been found between racial groups, than in the current case.

Second, the clinician improvement ratings reported here are based on subjective judgments. Clinical outcome is best measured with objective psychometric instruments, administered by neutral research assistants, since clinicians who are directly involved in providing treatment are inclined to view their work in a positive light, and thus to make biased ratings. It is likely that the improvement ratings reported here reflect the quality of the relationship between clinician and veteran as well as actual clinical improvement.

A final limitation concerns our use of quasi-experimental rather than experimental design. One would have greater confidence in our findings if veterans had been randomly assigned to black and white clinicians and if the numbers of veterans treated by black and white clinicians were more equal. Such methodological improvements would be more practical in a controlled clinical trial than in a descriptive program evaluation study of the type presented here.

This study has six major strengths that also deserve

attention: 1) baseline clinical and social adjustment status was measured through multiple standardized measures allowing statistical adjustment for differences between blacks and whites in these areas; 2) the sample was diagnostically homogeneous; 3) since virtually no veterans are charged for VA services, findings on program participation are not confounded by differences in ability to pay; 4) the sample is large and nationally distributed across 53 different medical centers located in every region of the country; 5) detailed information was gathered on clinician characteristics other than race; and 6) process and outcome data cover a broad array of treatment domains, each of which is assessed with multiple measures.

Intensity of program involvement

Although, in a previous study involving a national community sample, we found that black veterans are just as likely as white veterans to have obtained mental health services from VA (18), data from the current study suggest that those black veterans who do obtain VA services are less involved in treatment than white veterans on measures of both the duration of treatment and number of sessions. This pattern of equal or higher than expected rates of initial participation, but reduced continued participation by black patients, has been observed in studies of several other large mental health systems including the Los Angeles county mental health system (8); a series of 17 Seattle-King County Community Mental Health Centers (4); and the Cuyahoga County, Ohio, community mental health system (5).

These participation and involvement patterns are best explained by a combination of patient, clinician and institutional factors (26). While black veterans are likely to seek mental health treatment, they may be reluctant, for sociocultural and historical reasons to expose themselves to intensive or extensive personal exploration. In the words of Pernell-Arnold, as quoted in Solomon (5), there is an ethos among black men that "You don't tell your secrets on the streets", or as Franklin (27) put it, "African-American men are not likely to share personal vulnerabilities. This tendency ...is a racial characteristic, given the psychohistory of betrayal in the lives of African American men." According to Bell et al. (28) black patients may respond defensively to their perceived powerlessness in treatment situations, or as suggested by Baker (29) "If Black patients believe the goal of therapy is to maintain the status quo and their place in society, they may be suspicious of the motives of Black as well as White psychiatrists."

Our data show that beyond this personal reserve, part of the observed racial differences in involvement is attributable to the specific interaction of black veterans and white clinicians. It is important to note that although both black and white clinicians judged black veterans to be less regular in their attendance than white veterans, and less personally committed to therapy, it was only when treated by white clinicians that these differences

resulted in significantly reduced duration of participation among blacks and lower numbers of treatment sessions. This evidence of problematic racial pairing is likely to be a product of both the fears and anxieties of white clinicians towards black veterans (26, 30) and the distrust and suspiciousness of black veterans towards white clinicians, especially those in positions of power (26, 31-33).

It is important to note in this context that, totally apart from the attitudes or behaviors of either individual veterans or particular clinicians, the institutional context of treatment may have a further negative influence on the perceptions of white clinicians by black veterans. The exceptionally harsh treatment of black soldiers in Vietnam has been documented in painful detail (14-15) and may add to the distrust some black veterans feel as they approach VA medical centers for help. In addition, as Baker (29) has suggested, in many cases the history of segregated and explicitly racist health care for blacks "produces an anticipatory anxiety in Afro-American patients as they approach a health care institution." Such institutional anxiety may well taint the initial encounter of black veteran and white clinician, regardless of their personal dispositions.

Treatment emphases

Beyond their less intensive involvement, as indicated by the amount of treatment received, black veterans were also less often involved in treatment activities that emphasized personal exploration (discussion of war trauma, insight-oriented psychotherapy, abreactive therapy and deconditioning negative affects). Here too, veteran, clinician and institutional factors are all likely to be at work. Suggestions in the literature that black men may be reluctant to reveal personal feelings have been noted above.

Geller (26) conducted a questionnaire study of the reaction of white clinicians to written descriptions of hypothetical patients, and found that they judged black patients to be less appropriate candidates for psychotherapy, felt less comfortable getting close to them, and expected more adverse reactions to treatment. Two important limitations of Geller's study are his use of hypothetical cases and the fact that he only studied white clinicians.

The data presented in this study of actual treatment situations show that on four measures (time spent discussing war traumas, deconditioning negative affects, providing insight-oriented therapy, and providing abreactive therapy), black clinicians, as well as white clinicians were less likely to be personally probing when they treated black veterans. On two of these measures these differences were greater for white clinicians than for black clinicians. It appears that both black and white clinicians are cautious with black patients, although white clinicians are significantly more so, on some measures.

It is also notable that, in spite of many suggestions in the literature that treatment of blacks tends to be more directive, more medically oriented and more concerned with external rather than internal issues (26), no differences were noted in the amount of time devoted to directive therapy or crisis intervention, or in the amount of time used to address external issues (e.g. current adjustment problems, physical illnesses, financial benefits and vocational counseling). The greater emphasis on substance abuse treatment among blacks, even after the severity of substance abuse as measured by standardized indices was controlled, may, however, reflect some tendency towards more directive treatment or towards a disproportionate emphasis on substance treatment problems among blacks. If so, this disproportionate emphasis is significant for both white and black clinicians. Thus, in contrast to the emphasis in the literature on the social distance between black patients and white clinicians (26, 34), we found less evidence of problematic racial pairing on measures of treatment emphasis than on more objective measures of treatment involvement and on ratings of improvement.

The less frequent use of psychotropic medications among black veterans seems to run counter to published accounts of over-diagnosis of psychosis and excessive use of antipsychotic medication among blacks (35). A recent study of severely mentally ill patients treated at a community mental health center showed that while blacks received higher doses of antipsychotic medications, and especially depot (i.e. long-acting intra-muscular) medications, like the veterans in this study, they were less likely to be prescribed nonneuroleptic psychotropics (36). Both a recent literature review on cultural factors in psychiatric treatment (37) and a recent study of racial factors in general medication use (38) suggest that blacks are, in general, less inclined to use medications than whites, even though a review by Lawson (39) suggests that blacks may be more responsive than whites to both phenothiazines and antidepressants. Since the prescribing differences presented here were significant for both black and white clinicians, and were not explained by differences in duration of involvement or number of sessions, they may to reflect veteran treatment preferences.

Improvement

In a study of 164 patients that used clinician rating methods quite similar to ours, Jones (10) found no differences in improvement between black and white clients and no effect of clinician race. Furthermore, in a more recent review article, Sue (12) also concluded that there is little evidence of differential treatment outcome among ethnic-minority groups. It is important to note, therefore, that while we found no significant black-white difference on any improvement measure when we controlled for the effect of clinician race, we did find evidence of diminished improvement on four measures when white clinicians treated black

veterans. Differences on two of these measures, violent behavior and sleep problems, are explained by differences in intensity of involvement and treatment emphasis, discussed above. Overall, these findings, like those reported by Sue (8), suggest a modest effect of racial pairing on clinical outcome, an effect that is considerably weaker than that for involvement in treatment.

In contrast to the global improvement measures presented by other researchers, our measures address 15 different outcome domains. It is specifically in the areas of reliving symptoms and emotional numbing that the match of white clinician with black veteran appears to be problematic. As one might expect from the previous discussion, these are symptom areas for which exploration of personal feelings and memories are central to treatment.

Proposed remedies

In view of evidence that black veterans receive less treatment than white veterans, and that these differences are partially attributable to the pairing of white clinicians and black veterans, several courses of action may be in order. As a result of the evidence of substantial premature termination among minorities in Seattle (4), steps were taken to increase the cultural sensitivity of services by hiring more minority clinicians, and by locating services in more accessible community settings, among others. A repeat study 10 years later suggested that these efforts did reduce the relative frequency of premature termination among minorities, although premature termination remained significantly greater for blacks than for whites (11). Such recommendations would seem to be applicable in VA.

A similar type of effort, the Vietnam Veterans Readjustment Counseling Service (Vet Center program) was initiated by VA, in 1978. This program, located in storefront settings across the country, has made special efforts to offer accessible nonmedical services provided by minority and Vietnam veteran peers. In spite of the success of this program (40), the proportion of black veterans among those seen for PTSD at Vet Centers (19%) (41) is only slightly greater than the proportion treated by the PCT program (17%) and in VA medical centers more generally (16%) (41). Since, as we have seen, initial participation rates do not necessarily reflect involvement, more detailed data are needed on the involvement of veterans in various racial groups in Vet Center programs.

Several scholars have described curricula designed to foster more effective handling of the issue of race in clinical encounters between blacks and whites (32, 42). All these approaches emphasize the importance of helping white clinicians overcome, not racial prejudice or bias, but their own discomfort, guilt, and anxiety about forthrightly addressing the issue of race as it emerges in the clinical setting. Others have advocated a series of pre-therapy meetings to help minority veterans achieve an understanding

of what they can derive from what may be a culturally alien treatment (43). Efforts to train and hire additional minority clinicians, experiential training activities for current clinicians, and modules addressing distinctive clinical needs of minority veterans might all be appropriate in VA.

While there is considerable disagreement as to the progress we have made in race relations as a society in recent decades (44), the data presented here show clearly that there is ground yet to be gained.

References

1. Watts CA, Scheffler RM and Jewell NP (1986) Demand for Outpatient Mental Health Services in a Heavily Insured Population, *Health Services Research* 21: 267-290
2. Horgan CM (1986) The Demand for Ambulatory Mental Health Services from Specialty Providers, *Health Services Research* 21: 291-320
3. Leaf PJ, Bruce ML, Tischler GL, Freeman DH, Weissman ML and Myers JK (1988) Factors Affecting the Utilization of Specialty and General Medical Mental Health Services, *Medical Care* 26: 9-26
4. Sue S (1977) Community Mental Health Services to Minority Groups, *American Psychologist* 32:616-624
5. Solomon P (1988) Racial Factors in Mental Health Service Utilization, *Psychosocial Rehabilitation Journal* 11: 3-12.
6. Mollica RF, Blum JD and Redlich F (1980) Equity and the Psychiatric care of the Black Patient, 1950-1975, *Journal of Nervous and mental Disease* 168: 279-286
7. Griffith MS and Jones EE (1978) Race and psychotherapy: Changing perspectives. In JH Masserman, *Current Psychiatric Therapies* 18: 225-235.
8. Sue S, Fijino DC, Hu L, Takeuchi DT and Zane NWS (1991) Community mental health services for ethnic minority groups: A test of the cultural responsiveness hypothesis *American Psychologist* 59:533-540
9. Acosta FX (1980) Self-described reasons for premature termination of psychotherapy by Mexican American, black American and Anglo-American patients. *Psychological Reports*, 47:435-443
10. Jones EE (1982) Psychotherapists' impressions of treatment outcome as a function of race. *Journal of Clinical Psychology* 38:722-731
11. O'Sullivan MJ, Peterson PD, Cox GB and Kirkeby J (1989) Ethnic populations: Community mental health services ten years later. *American Journal of Community Psychology* 17: 17-30
12. Sue S. Psychotherapeutic Service for Ethnic Minorities (1988) *American Psychologist* 43:301-308
13. Kulka RA, Schlenger WE, Fairbank JA, Hough RL, Jordan BK, Marmar, CR and Weiss DA (1990) Trauma and the Vietnam War Generation: Report of Findings from the National Vietnam Veterans Readjustment Study. New York, Brunner/Mazel

14. Terry W (1984) *Bloods: An Oral History of the Vietnam war by Black Veterans*, New York, Random House
15. Parson ER (1985) Ethnicity and Traumatic Stress: The Intersecting Point in Psychotherapy, in CR Figley (Ed) *Trauma and Its Wake*, Volume I. New York, Brunner/Mazel
16. Scott K (1993) Minority Health: VA Efforts Questioned, U.S. Medicine, 19: 22-23 (October 1993).
17. Rosenheck RA and Massari LA (1993) Wartime Military Service and Utilization of VA Health Care Services. *Military Medicine* 158: 223-228
18. Rosenheck RA and Fontana AF (1994) Utilization of Mental Health Services by Minority Veterans of the Vietnam Era (see Chapter 2 of this volume).
19. Fontana A, Rosenheck R, and Spencer H. (1990) The Long Journey Home: The First Progress Report on the Department of Veterans Affairs PTSD Clinical Teams Program. Northeast Program Evaluation Center, Evaluation Division of the National Center for PTSD, Department of Veterans Affairs Medical Center, West Haven, Connecticut
20. Laufer RS, Yager T, Frey-Wouters E, and Donnellan J (1981) *Legacies of Vietnam*. Vol. III. Post-War Trauma: Social and Psychological Problems of Vietnam Veterans and Their Peers; House Committee Print No. 14, U.S. Government Printing Office, Washington, D.C.
21. Spitzer RL, Williams JBW (1985) Structured clinical interview for diagnosis. New York, New York State Psychiatric Institute
22. McLellan AT, Luborsky L, Cacciola J, Griffith J, Evans F, Barr HL, and O'Brien CP (1985) New data from the Addiction Severity Index: Reliability and validity in three centers. *Journal of Nervous and Mental Disease* 173:412-423
23. Ewing JA (1984) Detecting alcoholism: The CAGE questionnaire. *JAMA* 252: 1905-1907
24. Robins LN, Helzer JE, Croughan, et al (1981) The National Institute of Mental Health Diagnostic Interview Schedule. *Archives of General Psychiatry* 38: 381-389.
25. Vernez G, Burnam MA, McGlynn EA, Trude S and Mittman BS (1988) Review of California's Program for the Homeless Mentally Disabled. Santa Monica, CA, Rand Corporation

26. Geller JD (1988) Racial bias in the evaluation of patients for psychotherapy in L Comas-Diaz and EEH Griffith (eds) Clinical Guidelines in Cross-Cultural Mental Health, New York, John Wiley
27. Franklin AJ (1992) Therapy with African American men. Families in Society: The Journal of Contemporary Human Services 73: 350-355
28. Bell CC, Bland IJ, Houston E and Jones BE (1983) Enhancement of knowledge and skills for the psychiatric treatment of Black populations. In Chunn JC, Dunston PJ, Ross-Sheriff F (Eds.) Mental Health and People of Color-Curriculum Development and Change, Washington, DC, Howard University Press.
29. Baker FM (1988) Afro-Americans in L Comas-Diaz and EEH Griffith (Eds.) Clinical Guidelines in Cross-Cultural Mental Health, New York, John Wiley
30. Jones BE, Gray BA (1985) Black and White Psychiatrists: Therapy with Blacks. Journal of the National medical Association 77:19-25
31. Grier WH and Cobbs PM (1968) Black Rage. New York, Bantam
32. Pinderhughes E (1989) Understanding race, ethnicity and power, New York, the Free Press
33. Griffith EEH and Baker FM (1993) Psychiatric care of African Americans in Gaw AC (Ed.) Culture, Ethnicity and Mental Illness, Washington, DC, American Psychiatric Press
34. Jones BE and Gray BA (1986) Problems in diagnosing schizophrenia and affective disorders among blacks. Hospital and Community Psychiatry 37: 61-65, 1986
35. Adiempe VT (1981) Overview: White norms and psychiatric diagnosis of black patients. American Journal of Psychiatry 138: 279-285
36. Glazer WM, Morgenstern H and Doucette J (1994) Race and tardive dyskinesia among outpatients at a CMHC. Hospital and Community Psychiatry 45: 38-42.
37. Lefley HP (1990) Culture and Chronic Mental Illness, Hospital and Community Psychiatry 41: 277-286
38. Fillenbaum GGT, Hanlon JT, Corder EH, Ziqubu-Page, Wall WE and Brock D (1993) Prescription and nonprescription drug use among black and white community residing elderly. American Journal of Public Health 83: 1577-1582
39. Lawson W (1986) Racial and Ethnic Factors in Psychiatric Research, Hospital and Community Psychiatry 37: 50-54

40. Blank AS (1993) Vet Centers: A new paradigm in delivery of services for victims and survivors of traumatic stress in Wilson JP and Raphael B (Eds.) International Handbook of Traumatic Stress Syndromes, New York, Plenum.
41. Ronis D, Bates EW and Wolff N (1992) 1990 Survey of Outpatient Mental Health and Readjustment Counseling Services: Analyses of Diagnoses and Problems, Ann Arbor, MI, Great Lakes HSR&D Field program
42. Bradshaw WH (1978) Training psychiatrists for working with blacks in basic residency programs. American Journal of Psychiatry 135: 1520-1525
43. Parson E (1993) Ethnotherapeutic empathy (EthE)-part II: Techniques in interpersonal cognition and vicarious experience across cultures. Journal of Contemporary Psychotherapy 23: 171-182
44. Sniderman PM and Piazza T (1993) The Scar of Race. Cambridge, MA, Harvard University Press

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Table 4.1. Sociodemographic and clinical characteristics, by race of veteran.

	Black N=910	White N=3,816	F	P
<hr/>				
Socio-demographic characteristics				
Age	43.83	46.29	71.3	0.0001
Married	0.30	0.50	125.3	0.0001
Working	0.47	0.55	6.6	0.0101
Personal Income	\$760	\$1,178	95.6	0.0001
VA Compensation	0.52	0.58	9.4	0.0022
War zone stress				
Combat exposure	10.73	10.53	3.7	0.0550
Illness characteristics				
PTSD (SCIO Sum)	1.51	1.51	0.2	0.6770
Psychiatric Problems (ASI)	0.57	0.56	0.2	0.6796
Alcoholism (CAGE)	1.66	1.22	56.4	0.0001
Drug Abuse (DIS)	0.88	0.46	132.3	0.0001
Medical Problem	0.56	0.53	2.3	0.1326

Key to significance of ANOVA:

a = p<0.05

b = p<0.01

c = p<0.001

d = p<0.0001

Table 4.2. Primary clinicians' characteristics by race of veteran.

	Clinician characteristics											
	Race		Gender		Profession			Veteran Status				
	Black	White	Male	Female	Medical	Non-medical	Other	Non-veteran	Vietnam veteran	non-Vietnam veteran		
Black veterans N= 910	139 15.3%	771 84.7%	590 64.8%	320 35.2%	210 23.1%	601 66.0%	99 10.9%	638 70.1%	114 12.5%	158 17.4%		
White veterans N=3,879	298 7.8%	3,518 92.2%	2,740 70.6%	1,139 29.4%	810 21.2%	2,442 63.9%	571 14.9%	2,484 65.1%	638 16.7%	694 18.2%		
Chi square P	48.46 0.0001		12.92 0.0001		17.95 0.006			15.24 0.0001				

Table 4.3. Comparison of treatment experience by race of veteran.

	- Veteran race -		F	p		
	Black	White				
	N=893	N=3,722				
Participation						
Involvement						
Termination after one session	4626	27.1%	24.8%	0.27		
Termination within 3 months	4583	40.6%	35.3%	7.89 c		
Duration of participation (mos.)	4650	4.58	5.46	5.21 a		
Total sessions	4626	18.01	23.02	7.54 b		
Individual sessions	4626	8.43	11.14	25.62 d		
Group sessions	4626	9.74	11.80	0.01		
Attendance (1-3)	3478	1.37	1.63	26.59 d		
Commitment to change (1-3)	3478	2.19	2.55	31.96 d		
Treatment emphasis						
Current adjustment problems	3643	1.78	1.79	3.46		
Discussing war trauma	3642	1.08	1.20	12.70 c		
Insight oriented therapy	3643	0.98	1.14	12.94 c		
Directive therapy	3643	0.89	0.85	0.02		
Abreactive therapy	3643	0.66	0.74	5.68 a		
Social skill training	3478	0.61	0.62	0.07		
Deconditioning negative affects	3642	0.38	0.49	8.13 b		
Physical illnesses	3642	0.37	0.40	2.72		
Substance abuse	3478	0.53	0.38	8.58 b		
Crisis intervention	3477	0.31	0.31	0.52		
Benefits assistance	3478	0.22	0.22	0.70		
Vocational counseling	3478	0.15	0.11	1.58		
Psychotropic medication (any type)						
Anti-depressant	4657	48.0%	57.6%	17.55 d		
Anxiolytic	4657	30.4%	40.7%	13.90 d		
Sleep medication	4657	18.1%	26.4%	23.42 d		
Improvement rating						
Violent behavior	2646	3.41	3.52	2.86		
PTSD symptoms, overall	3303	3.40	3.50	0.61		
Drug problems	678	3.52	3.43	2.20		
Alcohol problems	1326	3.40	3.44	0.00		
Numbing symptoms	3106	3.32	3.45	1.95		
Sleep problems	3082	3.31	3.41	2.37		
Reliving symptoms	3124	3.29	3.39	0.66		
Social isolation	2565	3.26	3.38	2.35		
Interpersonal relationships	2522	3.21	3.37	1.43		
Non-PTSD psychiatric problems	1052	3.28	3.30	0.09		
Basic resources (housing, income)	1321	3.23	3.24	0.59		
Financial status	1887	3.15	3.23	2.89		
Employment	1859	3.12	3.17	0.39		
Legal problems	593	3.12	3.14	0.43		
Medical problems	1543	3.04	3.06	2.60		

Key to significance of ANCOVA:

81

a = p<0.05 c = p<0.001

b = p<0.01 d = p<0.0001

Table 4.4. Comparison of treatment experience by race of clinician and race of veteran (1).

	White clinician		Black clinician		ANCOVA	Comparison of means (Tukey<0.05)	Problem pairing			
	1-Black Veteran N=292	2-White Veteran N=3,430	3-Black Veteran N=135	4-White Veteran N=758						
Participation										
Involvement										
Terminated after one session	29.5%	25.4%	14.1%	18.9%	16.09	d	1,2>3,4			
Termination within 3 months	41.9%	36.0%	33.1%	27.4%	12.74	d	1>2,4; 2>4			
Duration of participation (mos.)	4.29	5.41	6.29	6.06	5.13	b	1<2,3,4			
Total sessions	16.56	22.69	25.26	26.03	12.02	d	1<2,3,4			
Individual sessions	7.64	10.96	12.88	13.25	18.30	d	1<2,3,4; 2<3			
Group sessions	9.12	11.66	13.27	12.68	4.01	b	1<2,4			
Attendance (1-3)	1.36	1.62	1.48	1.73	10.85	d	1<2,4; 3<4			
Commitment to change (1-3)	2.13	2.53	2.48	2.77	13.85	d	1<2,3,4; 2,3<4			
Treatment emphasis										
Current adjustment problems	1.78	1.78	1.83	1.90	5.43	b				
Discussing war trauma	1.07	1.18	1.15	1.36	8.57	d	1<2,4; 2<4			
Insight oriented therapy	0.88	1.10	1.44	1.55	28.11	d	1<2,3,4; 2<3,4			
Directive therapy	0.81	0.82	1.26	1.18	28.26	d	1,2<3,4			
Abreactive therapy	0.64	0.73	0.77	0.90	17.27	d	1,2<4			
Social skill training	0.61	0.62	0.64	0.70	4.47	b				
Deconditioning negative affects	0.35	0.47	0.55	0.64	9.62	d	1<2,3,4; 2<4			
Physical illnesses	0.34	0.38	0.55	0.60	6.88	d	1,2<3,4			
Substance abuse	0.49	0.36	0.75	0.48	25.41	d	1>2; 3>1,2,4			
Crisis intervention	0.28	0.31	0.43	0.33	2.92	a				
Benefits assistance	0.21	0.22	0.29	0.23	6.33	c				
Vocational counseling	0.15	0.11	0.18	0.14	7.46	d				
Psychotropic medication (any type)										
Anti-depressant	46.5%	56.9%	55.9%	66.1%	6.28	c	1<2,4; 2<4			
Anxiolytic	30.8%	40.2%	27.9%	46.6%	6.77	d	1<2,4; 3<2,4			
Sleep medication	17.4%	26.0%	22.1%	31.2%	8.74	d	1<2,4			

(1) Key to significance of ANCOVA:

a = p<0.05 c = p<0.001
 b = p<0.01 d = p<0.0001

(*) = Problematic racial pairing.

Table 4.4 (continued) Comparison of treatment experience by race of clinician and race of veteran (1).

	White clinician		Black clinician		ANCOVA	Comparison of means	Problem racial pairing
	1-Black	2-White	3-Black	4-White			
Veteran	Veteran	Veteran	Veteran	N=135	N=758	F	p (Tukey<0.05)
Improvement rating							
Violent behavior	3.35	3.52	3.71	3.56	6.48	c 1<2,3,4	Yes
PTSD symptoms, overall	3.38	3.50	3.50	3.50	0.94		
Drug problems	3.44	3.43	3.95	3.43	4.45	b 1,2<3	
Alcohol problems	3.35	3.43	3.67	3.56	3.69	b	
Numbing symptoms	3.28	3.45	3.56	3.43	5.05	b 1<2,3	Yes
Sleep problems	3.25	3.41	3.56	3.43	4.11	b 1<2,3,4	Yes
Reliving symptoms	3.24	3.38	3.55	3.47	4.87	b 1<2,3,4	Yes
Social isolation	3.23	3.40	3.42	3.19	4.50	b 1,4<2	
Interpersonal relationships	3.18	3.39	3.34	3.21	2.91	a 1,4<2	
Non-PTSD psychiatric problems	3.28	3.29	3.26	3.47	2.13		
Basic resources (housing, income)	3.18	3.25	3.43	3.14	2.96	b	
Financial status	3.12	3.23	3.30	3.23	2.50		
Employment	3.09	3.18	3.24	3.06	1.91		
Legal problems	3.11	3.16	3.18	3.06	0.15		
Medical problems	2.96	3.05	3.32	3.15	3.48	a 1,2<3	

(1) Key to significance of ANCOVA:

a = p<0.05 c = p<0.001

b = p<0.01 d = p<0.0001

(*) = Problematic racial pairing.

**Chapter 5 -
Race and Outcome of
Treatment for Veterans Suffering from PTSD
by
Robert Rosenheck and Alan Fontana**

Abstract

Background: This study examines the relationship between racial group membership and psychometrically measured outcomes 4, 8 and 12 months after program entry in a program for veterans seeking treatment for war-related posttraumatic stress disorder (PTSD). It seeks to determine whether there are significant differences in clinical outcome between black and white veterans when: 1) standard psychometric instruments are used to assess change; 2) change is measured in multiple psychological and psychosocial outcome domains, including satisfaction with services; and 3) data are gathered by non-treatment staff.

Methods: Longitudinal assessment data were gathered and used to compare service use, clinicians' improvement ratings and psychometrically assessed clinical change among black ($N=122$) and white ($N=403$) veterans treated at six geographically diverse sites. Outcome domains included psychiatric symptoms, substance abuse, employment, violent behavior, criminal behavior, social relationships, and physical health.

Results: There were no significant differences between blacks and whites on any of the clinicians' improvement ratings, or on 13 of the 17 outcome measures. During the first 4 months of treatment white veterans showed more improvement than blacks on psychiatric symptoms, while blacks showed more improvement in days worked and satisfaction with services. During the following eight months blacks showed more improvement than whites on psychological distress but also a relative decline in days worked.

Conclusion: In this prospective study of veterans suffering from long-standing, severe PTSD, no consistent or sustained differences were observed between racial groups in improvement, whether measured as psychometric change or by clinician's ratings.

I. Background

For several decades both clinicians and researchers have expressed concern that patients belonging to ethnocultural minority groups, and particularly blacks, derive less benefit from conventional psychotherapeutic treatments than whites (1). While most empirical studies have failed to demonstrate differences in outcome between black and white patients (1-3), a large study of over 13,000 patients treated in the Los Angeles County Mental Health system recently reported that blacks were least likely of four ethnocultural groups to show improvement, and that outcomes for blacks were not significantly better when treatment was provided by black clinicians (4).

Particular concern has been expressed in recent years that the distinctive clinical needs of black Vietnam veterans are not being met by conventional treatments, and especially by treatment provided by the Department of Veterans Affairs (5-6). Black veterans faced an exceptionally complex series of traumatic military and socio-political experiences during Vietnam service (7), and Parson (8) has suggested that these complexities make treatment of black veterans especially difficult.

Although blacks have been found to be less likely than whites to use non-VA mental health services (9), previous studies have shown that blacks are more likely than whites to have used VA services (even after adjustment for differences in eligibility and income) and no less likely than whites to have used VA mental health services (10, 11). In an examination of outpatient treatment of almost 5,000 Vietnam veterans in VA's national PTSD Clinical Teams (PCT) program, no differences in improvement were observed between black and white veterans when the effect of clinicians' race was statistically controlled (12). When the pairing of clinicians' and veterans' races was considered, however, blacks showed less improvement than whites, when treated by white clinicians. In this study, as in that of Sue et al. (4), assessments of clinical improvement were based on clinicians' ratings, rather than on standardized psychometric instruments.

In the current study, we compare outcome of treatment across racial groups at a subset of six PCTs to determine whether the overall finding of the larger VA study, that there are no differences in clinical outcome between black and white veterans, is sustained when: 1) standard psychometric instruments are used to assess change; 2) change is measured in multiple psychological and psychosocial outcome domains, including satisfaction with services; and 3) data are gathered by non-treatment staff.

II. Methods

Data gathered for this study were derived from structured interviews conducted as one phase of the national evaluation of

VA's PCT program. Six PCTs, located in Boston, MA; Jackson, MS; Kansas City, MO; New Orleans, LA; Providence, RI; and San Francisco, CA agreed to participate in a descriptive outcome study. Four of the six teams were led by nationally recognized experts in the treatment of PTSD. During 1990-1991, 554 male veterans of World War II, Korea and Vietnam completed baseline assessments and were reinterviewed again, at four-month intervals, for one year. Because of the small number of hispanic veterans treated at these sites, comparisons presented here involve only whites (N=403) and blacks (N=122).

The veterans in this sample averaged 45.2 years old; 85% served in Vietnam and 15% in World War II or Korea. They had 12.8 years of education, and only 50% were married. Only 35% had worked during the previous month and 57% were receiving VA compensation payments.

Measures of Clinical Status, Patient Satisfaction, and Social Adjustment.

Because war-related PTSD is a potentially persistent and disabling disorder, outcomes were measured in multiple symptom and functional domains in addition to PTSD symptomatology.

PTSD, psychological symptoms and medical problems. PTSD symptoms were assessed by the Mississippi Scale for Combat-Related PTSD (13) while guilt reactions to war zone experiences were assessed by the War Guilt Scale (14). General psychological distress was assessed by two indices: the General Severity Index of the Brief Symptom Inventory (BSI) (15) and the Psychiatric Symptoms Composite score from the Addiction Severity Index (ASI) (16). Special attention was also paid to the assessment of suicidal behavior. Reported suicide attempts during the 30 days prior to baseline and the four months before follow-up interviews were represented by dichotomous (0=no, 1=yes) variables. ASI Alcohol and Drug composite indices were used to measure the severity of substance abuse problems (16), and medical difficulties were assessed with the ASI Medical Composite index. A six-item violent behavior index was based on the measure used in the National Vietnam Veterans Readjustment Study (17).

Satisfaction. Veterans' satisfaction with specialized PTSD treatment was assessed using a five-point scale (1=very dissatisfied, 2=dissatisfied, 3=indifferent, 4=satisfied, and 5=very satisfied). Only veterans who were receiving such treatment from the PCT answered this question. Baseline measures of satisfaction referred to prior treatment for PTSD at VA medical centers.

Community adjustment. Family relationships were represented by the ASI Family stress index, while social contact and daily activities were assessed by a count of the number of people to whom the veteran felt emotionally close, an index reflecting how often

these people were seen, and an index of daily activities (18). Employment was assessed by the number of days that the veteran worked during the preceding month. Current difficulties with the criminal justice system were assessed with the ASI Legal Difficulties composite index.

VA Compensation status. Receipt of VA compensation was measured by an index specially constructed to encompass the full range of compensation levels. Veterans without service-connection received a value of "0"; those who were service-connected at 0% received a value of "1"; those who were service-connected at 10% or more but less than 50% received a value of "2"; those who were service-connected at 50% or more but less than 100% received a value of "3"; and those who were service-connected at 100% received a value of "4".

Clinician improvement ratings. Each veteran's primary clinician rated his clinical improvement since the initiation of contact with the program for 15 separate domains (listed in table 3) using a 5-point scale: 0=substantial deterioration; 1=some deterioration; 2=no change; 3=some improvement; 4=substantial improvement. Ratings were only made for veterans who were identified as having a problem in the domain under consideration. The improvement rating used for this study was the last one reported for each veteran. Unfortunately, data on the reliability and validity of this measure are not available.

Measures of Participation in Treatment.

The participation of veterans in PCT treatment was monitored with a structured clinical summary completed by PCT clinicians 2, 4, 8 and 12 months after each veteran entered treatment. This summary allowed determination of: 1) the duration of veterans' participation in treatment for up to one year; 2) the number of treatment sessions; 3) clinical emphases in the treatment. Data on treatment sessions were summed across the entire year, while data on clinical emphases were averaged across the reporting points. Data on non-PCT and non-VA service utilization were derived from the follow-up assessments.

Plan of Data Analysis. The analysis was conducted in several stages. First, blacks and whites were compared on measures of socio-demographic status, baseline clinical status, and social adjustment using t-tests and chi-square tests. Variables that differentiated the two groups were statistically controlled in subsequent analyses of covariance (ANCOVAs), and dichotomous site codes were included for N-1 sites to adjust for effects that were specific to one or another site.

Previous analyses of this data set demonstrated that there were two phases of outcome over the first year: a movement phase, (the first four months) in which significant gains were realized, and a stabilization phase (the remaining eight months) during which

gains were maintained but not extended (19). Analysis of change was therefore conducted in two series: one evaluating change from the beginning of treatment to four months (the movement phase), and the second evaluating change for the remainder of the year, at four, eight and 12 months following intake (the stabilization phase).

To examine the relationship of racial group to outcome, these analyses were conducted as random regression analyses of longitudinal data (see below) in which race was examined for its interaction with outcome over time. A significant interaction means that either the degree or direction of change in outcome is significantly different for veterans in different racial groups.

Missing longitudinal data

Attempts to track adjustment longitudinally are subject to the problem of missing data at one or more of the time-points. Various methods have been used in order to try to compensate for this problem, including using data only from subjects for whom complete data are available, using data only from subjects who completed the study, using only the first and last time-points for each subject, or plugging missing time-points with the means. Each of these methods exacts a cost in the representativeness of the data.

Fortunately, a new approach to this problem, random regression modeling has been developed by statistical researchers in recent years (20). The random regression approach uses the available data to make the best estimate of the missing data for each subject by imputing values and performing the desired analyses. In this way, the maximum amount of information in the data set is used, with minimum distortion due to selective dropping of cases or time-points. We used program 5V (21) of the BMDP statistical package for the analyses in this study.

III. Results

Comparison of veterans on baseline characteristics.

Table 5.1 shows that, in this sample, blacks were significantly younger than whites and scored significantly higher on measures of PTSD symptoms and psychological distress. Blacks were less likely than whites to be married, but reported more close friends, although they also reported fewer daily activities than whites. Black veterans worked fewer days in the previous month, and had lower incomes than whites.

Participation in Treatment.

Table 5.2 shows that there was only one significant difference between blacks and whites out of 18 measures of participation in treatment. Clinicians reported spending less time discussing war traumas with black than with white veterans.

Comparison of change among blacks and whites.

Table 5.3 shows that there were no significant differences

between black and white veterans on any of the clinician improvement ratings.

Table 5.4 shows the results of random regression analyses of symptom and satisfaction measures over time, comparing blacks and whites during both the movement and stabilization phases. Analyses of measures of social adjustment are presented in Table 5.5. Separate Wald chi-square values are presented in each table, for each phase, reflecting: 1) significant differences between racial groups across all time points, 2) significant change over time, and 3) significant interactions between race and change over time, the principal focus of this study. The means for the "4 Months" time-point differ slightly between the analyses for the movement and stabilization phases because the inclusion of different time-points contributed slight variations to the imputation of missing values.

Overall differences by race. Overall, blacks and whites differed significantly on only three measures: blacks had higher levels of psychological distress (measured on the BSI) (Table 5.3), were close to more people (Table 5.4), and had higher levels of social contact.

Change over time. Significant improvement in this sample of veterans was observed eight of fifteen outcome measures. During the first four months of treatment, significant reductions were noted for alcohol abuse, drug abuse, and violent behavior, but not for PTSD or other psychological/psychiatric symptoms. Suicide attempts were reported more frequently, but this difference may reflect the fact that the baseline measure concerned only the previous 30 days, in contrast to the previous 120 days for each follow-up interview (Table 5.3). Satisfaction with treatment increased. There were no significant changes in any measure during the stabilization phase.

Table 5.5 shows that there were significant improvements in employment and legal problems during the movement phase, and that VA disability status increased. The overall improvement in days worked, however, was reversed during the later eight months of treatment.

Interaction of race and change over time. Significant interactions between race and change were observed for two symptom measures (Table 5.4), for patient satisfaction (Table 5.4), and for one measure of social adjustment (Table 5.5). During the movement phase, blacks showed an increase in psychiatric symptoms (on the ASI), while whites showed a decline. During the stabilization phase, in contrast, symptoms of psychological distress (BSI) increased among whites and declined among blacks. Blacks also showed a significantly greater increase in satisfaction with services over their pre-PCT treatment experience during the first four months of PCT treatment.

Table 5.5 shows that during the movement phase, blacks showed

more improvement than whites in days worked, but that they then showed a greater reduction in days worked during the stabilization phase.

IV. Discussion

This study sought to determine whether veterans' race was associated with differences in the outcome of treatment of PTSD over a 12-month period when outcome was measured psychometrically and assessed by pre/post change. Consistent with a larger study there were no significant differences in improvement according to clinicians' one-time ratings. The validity of this finding was generally confirmed by psychometric measurements. Although whites showed somewhat greater improvement in psychiatric symptoms and blacks showed somewhat greater gains in employment during the first four months of treatment, these differences were relatively isolated findings and were offset by trend reversals during the next eight months. Client race did not, in itself, appear to be associated with differences in clinical improvement.

Although many clinician reports and some simulation experiments have suggested that minorities do less well in psychotherapy than whites (22-24), the results of our study are similar to those of most other outcome studies in reporting no measurable differences in outcome between racial groups (1-3). The current study thus confirms the findings of a previous, and considerably larger, study of clinical outcome in VA's PCT program that relied on clinician ratings rather than independent psychometric assessments (12).

A caveat with respect to the current study is that, although racial differences in improvement were minimal, the sample studied was distinguished by a high degree of severity and prolonged duration of illness, and did not show significant improvement on several important measures. It is possible that racial differences in clinical improvement might have been more apparent in the presence of more robust main effects.

An important exception to the findings reported in this study and the other studies cited above is the large-scale investigation by Sue et al. (4) of racial factors in the treatment of patients in the Los Angeles County Mental Health system. In that study, blacks showed significantly less improvement than whites, even when treated by black clinicians. In our previous study of VA's PCT program (12) blacks were found to show more improvement on clinicians' ratings when treated by black clinicians than by white clinicians. Only one black clinician was involved in the current study, however, precluding any examination of the relationship of racial matching to treatment outcomes. The difference in findings between the Los Angeles County study and the two VA studies may be attributable to differences in staff qualifications (the LA system included paraprofessionals while VA staff are almost all masters-

prepared or doctoral level clinicians), or some other aspects of organizational culture. Studies of racial differences in outcome in other mental health systems are needed to determine whether service system characteristics may affect some racial groups more than others.

In our previous study of VA's PCT program (12), even though no differences were noted in improvement between blacks and whites, blacks were found to receive significantly less intensive and less personally probing services than whites. Racial differences in participation in treatment were not detected in the current study, perhaps because of the smaller sample size, or because of differences between the 6 sites involved in this study and the 47 other sites in the larger study.

The studies of VA's PCT program suggest that blacks and whites experience similar degrees of improvement in symptoms and in community adjustment, and express similar levels of satisfaction with services. These findings are somewhat reassuring in view of evidence that black veterans often receive less intensive services than whites, especially when treated by white clinicians (12). Since in the current study, there were only minimal differences in services received by black and white veterans, we can not evaluate the relationship of differences in service delivery to outcomes for different racial groups. Further studies are thus needed to determine under what circumstances blacks and white receive different levels of services, and the effect of those differences on clinical outcomes.

References

1. Sue S. Psychotherapeutic Service for Ethnic Minorities (1988) American Psychologist 43:301-308.
2. Jones EE (1978) effect of race on psychotherapy process and outcome: An exploratory investigation. Psychotherapy: Theory, research and practice 15: 226-236.
3. Jones EE (1982) Psychotherapists' impressions of treatment outcome as a function of race. Journal of Clinical Psychology 38:722-731
4. Sue S, Fijino DC, Hu L, Takeuchi DT and Zane NWS (1991) Community mental health services for ethnic minority groups: A test of the cultural responsiveness hypothesis American Psychologist 59:533-540
5. Allen I (1986) Posttraumatic stress disorder among black Vietnam veterans, Hospital and Community Psychiatry 37: 55-61
6. Scott K (1993) Minority Health: VA Efforts Questioned, U.S. Medicine, 19: 22-23 (October 1993).
7. Terry W (1984) *Bloods: An Oral History of the Vietnam war by Black Veterans*, New York, Random House.
8. Parson ER (1985) The Intercultural Setting: Encountering Black Vietnam Veterans, in Sonnenberg S, Blank AS and Talbott JA (eds) *The Trauma of War: Stress and Recovery in Vietnam Veterans*, Washington, DC, American Psychiatric Press, 1985.
9. Padgett DK, Patrick P, Burns BJ and Schlesinger HJ (1994) Ethnicity and the Use of Outpatient Mental Health Services in a National Insured Population, American Journal of Public Health 84:222-226.
10. Rosenheck RA and Massari LA (1993) Wartime Military Service and Utilization of VA Health Care Services. Military Medicine 158: 223-228.
11. Rosenheck RA and Fontana AF. Racial Factors in the Outpatient Treatment of Veterans Suffering from Posttraumatic Stress Disorder (see Chapter 2 of this report).
12. Rosenheck RA, Fontana AF, and Cottrel C Racial factors in the outpatient treatment of veterans suffering from Post-Traumatic Stress Disorder (see Chapter 4 of this report).
13. Keane TM, Caddell JM, Taylor, KL (1988) The Mississippi scale for combat related PTSD: Studies in reliability and validity. Journal of Consulting and Clinical Psychology 56: 85-90.

14. Laufer RS and Frey-Wouters E (1988) War trauma and the role of guilt in post war adaptation. Presentation at a meeting of the International Society for Traumatic Stress Studies and Parsons, Dallas Texas, October 22-26, 1988.
15. Derogatis LR and Melisaratos N (1983) The brief symptom inventory: An introductory report. *Psychological Medicine* 13: 595-605.
16. McLellan AT, Luborsky L, Cacciola J, Griffith J, Evans F, Barr HL, and O'Brien CP (1985) New data from the Addiction Severity Index: Reliability and validity in three centers. *Journal of Nervous and Mental Disease* 173:412-423.
17. Kulka RA, Schlenger WE, Fairbank JA, Hough RL, Jordan BK, Marmar, CR and Weiss DA (1990) Trauma and the Vietnam War Generation: Report of Findings from the National Vietnam Veterans Readjustment Study. New York, Brunner/Mazel.
18. Katz MM and Lyerly SB (1963) Methods for measuring adjustment and social behavior in the community: I. Rationale, description, discriminative validity and scale development. *Psychological Reports* 13: 505-535
19. Rosenheck RA and Fontana AF (in press) From Soldier to Civilian: Treatment of Veterans Severely Impaired by PTSD, in Ursano RJ and Norwood AE (eds) Those Left Behind and Those Who Returned: Psychological Responses to War in Families, Children and Survivors
20. Gibbons RD, Elkin I, Waternaux C, Kraemer HC, Greenhouse JB, Shea MT, Imber SD, Sotsky, SM, and Watkins JT (in press) Some conceptual and statistical issues in analysis of longitudinal psychiatric data. *Archives of General Psychiatry*.
21. Schluchter, MD (1988) 5V: Unbalanced repeated measures models with structured covariance matrices. In Dixon, W.J. (ed.) BMDP Statistical Software Manual. Vol. 2. Berkeley, CA, University of California Press, 1081-1114.
22. Parson ER (1985) Ethnicity and Traumatic Stress: The Intersecting Point in Psychotherapy, in CR Figley (Ed) Trauma and Its Wake, Volume I. New York, Brunner/Mazel.
23. Jackson GJ (1968) Cross-cultural Counselling with Afro-Americans, in P Pederson (Ed) Handbook of Cross-Cultural Counseling and Therapy. Westport, CT, Greenwood Press.
24. Penk WE and Allen IM (1989) Clinical Assessment of Post-Traumatic Stress Disorder (PTSD) Among American Minorities who Served in Vietnam, *Journal of Traumatic Stress* 4:41-66.

25. Robins LN, Helzer JE, Croughan, et al (1981) The National Institute of Mental Health Diagnostic Interview Schedule. Archives of General Psychiatry 38: 381-389.

Table 5.1. Veteran characteristics by race (6 PCT follow-up sites).

	White (N=403)	Black (N=122)	t (1)	Chi Square
Age	45.89	43.03	5.2 d	
Combat exposure	10.47	10.77	1.1	
Abusive violence in VN	0.29	0.31		0.87
Mississippi Scale Sum	121.98	126.67	2.02 a	
War Guilt Scale	2.64	2.82	1.72	
Psychiatric Problems (ASI)	0.53	0.57	1.7	
Psychological Distress (BSI)	2.04	2.29	2.86 b	
Attempted Suicide	0.33	0.30	0.55	
Alcoholism (ASI)	0.11	0.11	0.09	
Drug Abuse (ASI)	0.03	0.05	1.67	
Medical Problems (ASI)	0.50	0.48	0.28	
Violent Behavior	9.24	10.22	1.47	
Married	0.54	0.38		12.9 a
Family Stress (ASI)	0.26	0.22	1.27	
Number of Close People	10.3	12.22	2.34 b	
Social Contacts	494.1	503.2	0.07	
Daily Activities	11.74	10.39	2.49 a	
Days Worked in Past Month	7.02	5.13	2.05 a	
Legal Problems (ASI)	0.08	0.12	1.59	
Personal Income	\$1,335	\$781	6.3 d	
VA Compensation	0.57	0.55		0.22

(1) Key.

a = p < 0.05

b = p < 0.01

c = p < 0.001

d = p < 0.0001

Table 5.2. Comparison of clinical contacts and clinical emphases among participants in the PCT follow-up study (1).

	White (N=403)	Black (N=122)	F (1)
Duration of Involvement (months)	7.2	6.2	0.22
Clinical Contacts (total for 12 months)			
PCT Contacts (2)	30.3	27.4	0.00
Individual	13.9	11.3	0.59
Group	11.3	10.2	0.42
Other VA clinical contacts	18.0	21.0	0.22
Non-VA clinical contacts	22.5	17.3	0.77
Clinical Time Committed To (3):			
Current Social Adjustment	1.71	1.66	0.74
Vocational Counseling	0.27	0.33	0.01
Social Skills Training	0.82	0.78	0.52
Crisis Intervention	0.70	0.77	0.37
Benefits counseling	0.09	0.09	2.32
Working Towards Psychological Insight	1.10	0.87	2.03
Directive Therapy	0.73	0.83	1.85
Deconditioning Negative Affects	0.31	0.24	0.32
Abreacting Negative Trauma-Related Affects	0.60	0.51	0.63
Discussing War Traumas	1.37	1.03	5.71 a
Substance Abuse Treatment	0.13	0.11	0.36
Physical Illness	0.32	0.27	0.04

(1) Significance of differences is adjusted for clinical and social adjustment variables that were different between whites and blacks, and for site differences ($\alpha = p < .05$).

(2) Includes individual, group, family, and other contacts.

(3) Scale values are 0 (no time); 1 (<10% of the time); 3 (50%>10% of the time); 4 (> 50% of the time).

Table 5.3. Clinician improvement ratings by race of veteran (1).

	White (N=403)	Black (N=122)	F
Violent behavior	327	3.48	3.50
PTSD symptoms, overall	405	3.52	3.56
Drug problems	80	3.14	3.35
Alcohol problems	145	3.25	3.03
Numbing symptoms	383	3.50	3.15
Sleep problems	376	3.48	3.49
Reliving symptoms	378	3.43	3.44
Social isolation	322	3.39	3.41
Interpersonal relationships	326	3.34	3.29
Basic resources (housing etc.)	188	3.16	3.28
Financial status	263	3.18	3.14
Employment	239	3.17	3.12
Legal problems	83	3.01	3.27
Medical problems	165	3.04	3.31

(1) Improvement is measured on a 5-point scale: 1= substantial deterioration, 2= some deterioration, 3= no change, 4 = some improvement, 5=substantial improvement.

Table 5.6. Means and Random Regression Analyses for Changes in Psychiatric Symptoms Over Time, by Race: PCI Follow-up Study (N=525).

	Race	Movement phase						Stabilization phase					
		Baseline		Chi square		Race X Time		Baseline		Chi square		Race X Time	
		4 months	n.s.	Race	Time	n.s.	3 months	12 months	Race	Time	n.s.	Race	Time
Mississippi Scale	White	122.14	120.16	n.s.	n.s.	n.s.	120.25	119.74	121.20	n.s.	n.s.	n.s.	n.s.
	Black	126.28	126.33				127.15	127.02	125.68				
Guilt Inventory	White	2.64	2.61	n.s.	n.s.	n.s.	2.59	2.61	2.66	n.s.	n.s.	n.s.	n.s.
	Black	2.81	2.86				2.85	2.87	2.84				
Brief Symptom Inv.	White	2.05	2.03	5.23 a	n.s.	n.s.	2.03	2.05	2.12	n.s.	n.s.	6.32 a	
	Black	2.29	2.33				2.36	2.37	2.31				
ASI-Psychiatric	White	0.53	0.50	n.s.	n.s.	6.95 b	0.49	0.49	0.50	n.s.	n.s.	n.s.	n.s.
	Black	0.57	0.60				0.60	0.62	0.60				
Suicide Attempt	White	0.04	0.04	n.s.	5.38 a	n.s.	0.04	0.05	0.03	n.s.	n.s.	n.s.	n.s.
	Black	0.02	0.08				0.08	0.08	0.06				
ASI-Alcohol	White	0.11	0.08	n.s.	8.52 b	n.s.	0.08	0.07	0.07	n.s.	n.s.	n.s.	n.s.
	Black	0.11	0.08				0.07	0.08	0.07				
ASI-Drugs	White	0.03	0.02	n.s.	7.55 b	n.s.	0.02	0.01	0.01	n.s.	n.s.	n.s.	n.s.
	Black	0.05	0.03				0.02	0.02	0.02				
ASI-Medical	White	0.50	0.46	n.s.	n.s.	n.s.	0.46	0.46	0.44	n.s.	n.s.	n.s.	n.s.
	Black	0.49	0.53				0.53	0.58	0.50				
Violence	White	9.33	6.06	n.s.	77.57 c	n.s.	5.93	5.91	5.91	n.s.	n.s.	n.s.	n.s.
	Black	10.23	7.81				7.79	7.95	7.12				
Satisfaction with PTSD Treatment (1)	White	3.21	3.24	n.s.	5.34 a	4.47 a	3.25	3.15	3.20	n.s.	n.s.	n.s.	n.s.
	Black	2.51	3.06				3.12	3.22	3.06				

(1) Includes only veterans receiving treatment for PTSD at the time of the interview (n=59 blacks and n=183 whites for the movement phase);
 n=94 blacks and n=293 whites for the stabilization phase).
 Key: a - p<0.05
 b - p<0.01
 c - p<0.001

Table 5.5. Means and Random Regression Analyses for Changes in Social Functioning and Resources Over Time, by Race: PCT Follow-up study (N=525).

		Movement Phase						Stabilization Phase						
		Race	Baseline	4 months	Chi square	Race	Time	Race X Time	4 months	8 months	12 months	Race	Time	Race X Time
ASI-family	White	0.26	0.24	n.s.	n.s.	n.s.	n.s.	n.s.	0.24	0.22	0.24	n.s.	n.s.	n.s.
	Black	0.23	0.26	0.26					0.26	0.23	0.19			
People Close To	White	10.23	10.12	16.68 c	n.s.	n.s.	n.s.	n.s.	10.20	10.15	10.33	12.94 c	n.s.	n.s.
	Black	12.46	12.61	12.82					12.82	11.71	12.46			
Social Contacts	White	492.4	484.7	n.s.	n.s.	n.s.	n.s.	n.s.	496.8	468.5	477.7	11.92 c	n.s.	n.s.
	Black	509.1	554.6						569.6	571.0	573.8			
Daily activities	White	11.63	11.54	n.s.	n.s.	n.s.	n.s.	n.s.	11.53	12.01	11.70	n.s.	n.s.	n.s.
	Black	10.41	10.13						10.16	9.93	9.96			
Days Worked	White	6.91	7.37	n.s.	14.13 c	7.83 b	n.s.	n.s.	7.61	7.78	7.07	n.s.	9.73 b	6.53 a
	Black	4.93	8.00						8.13	6.34	6.15			
ASI-Legal	White	0.08	0.06	n.s.	6.28 a	n.s.	n.s.	n.s.	0.05	0.05	0.06	n.s.	n.s.	n.s.
	Black	0.11	0.07						0.07	0.08	0.03			
Service Connection	White	1.24	1.32	n.s.	12.25 c	n.s.	n.s.	n.s.	1.35	1.35	1.40	n.s.	n.s.	n.s.
	Black	1.08	1.15						1.14	1.16	1.13			

Key: a - p<0.05
b - p<0.01
c - p<0.001

WRITTEN COMMITTEE QUESTIONS AND THEIR RESPONSE

QUESTIONS SUBMITTED BY
HONORABLE LANE EVANS, CHAIRMAN
SUBCOMMITTEE ON OVERSIGHT & INVESTIGATIONS
COMMITTEE ON VETERANS' AFFAIRS

HISPANIC VETERANS: CONTRIBUTIONS TO THE NATION AND COMMUNITY,
RECEIPT OF FEDERAL VETERANS BENEFITS AND RELATED ISSUES

SEPTEMBER 28, 1994

QUESTIONS FOR MR. ANDREW RODRIGUEZ
DVOP/LABOR SERVICES REPRESENTATIVE
NEW YORK DEPARTMENT OF LABOR
NEW YORK, NEW YORK

1. What added collaboration is needed between VA Vet Centers and the Department of Labor, how can this be accomplished and how will veterans benefit?
2. Why is on-the-job training now more difficult for veterans to obtain, as reported in your prepared statement?
3. As staffing to operate the basic public labor exchange has been reduced, have veterans staff assumed more responsibilities of the basic public labor exchange?
4. How has Hispanic Heritage Month been recognized by the New York Department of Labor?
5. What are the special or unique needs of Hispanic veterans and how can the Federal government best respond to these special or unique needs?

RESPONSE TO QUESTIONS SUBMITTED BY
HONORABLE LANE EVANS, CHAIRMAN
SUBCOMMITTEE ON OVERSIGHT & INVESTIGATIONS
COMMITTEE ON VETERANS' AFFAIRS

DECEMBER 7, 1994

BY MR. ANDREW RODRIGUEZ
DVOP/LABCR SERVICES REPRESENTATIVE
NEW YORK STATE DEPARTMENT OF LABOR
NEW YORK, NEW YORK

1. VA Vet centers staff can work with DOL under our roof - centralize our services for employment - "One Stop Shop" focus true community "Total" services - save dollars \$ \$.

To include workshops in:

- Skills Assessment
- Resume Development
- Vocational Counseling
- Stress Management
- Interviewing Techniques
- Self Marketing Methods
- And Much More.

End Result:

- Total Quality Case Management
- Team Approach to Employment

2. The DOD, VA and DOL VETS Program are not taking their vested interest (\$/monies) and investing it in a positive media image campaign to promote:

- The Hiring of Qualified Veterans
- Total Quality Service By Employees
- PSA's usage that promotes success

3. Veteran staff has assumed more of the responsibilities of the basic public labor exchange. In addition to this, Veteran staff also assumed the negative image affecting Public Service. Much of the public using DOL services say:

- "DOL/UI is behind on my UI payments."
- "They only find low paying jobs."
- "My last resort for employment."
- "Not enough positive staff support."

4. "The Future is in Your Hands" celebrating Puerto Rican (Hispanic) Discovery Month (in NY State) focused its attention on elementary school students. Whatever happened to our Recently Separated Veterans, our young Veterans in colleges that are today building our future economy. Again, not enough positive attention is being given to the "be the best you can be" image after leaving military service. Emphasis on BiLingual Media Marketing promoting Hispanic Veterans' contributions to the U.S.
5. Hispanic Veterans need to feel - not special or unique - but as part of - not as castaways - respected as contributors to this great country. History books must be rewritten to recognize the many richly significant hispanic contributions to our American history.

In every major conflict since the Revolutionary War, Hispanics have gallantly fought and often sacrificed their lives in defense of our country. Thirty-nine Hispanic Veterans have received the Congressional Medal of Military Honor.

We need to better promote a positive Veterans' image and reach into our Hispanic/American communities across the country with school outreach programs recognizing the military contributions of Hispanic/American Veterans.

Once again, I wish to extend my thanks to Congressman Lane Evans and his Committee on Veterans' Affairs for holding Hearings and asking important questions focusing attention on "Hispanic Veterans, Veterans' Readjustment Benefits and Related Issues."



Andrew Rodriguez
DVOP/Labor Services Representative

PUERTO RICAN VETERAN'S ASSOCIATION OF MASSACHUSETTS, INC.
Springfield Bilingual Veteran's Outreach Center



Executive Director
 Gumersindo Gomez

P.O. BOX 70185, 186 MILL STREET
 SPRINGFIELD, MA 01107

(413) 731-0184

FAX # (413) 736-2008

President
 Sergio Kentish

December 1, 1994

Congressman Lane Evans
 Congress of the United States
 Committee on Veterans' Affairs
 Washington, DC 20515-6335

Dear Congressman Evans:

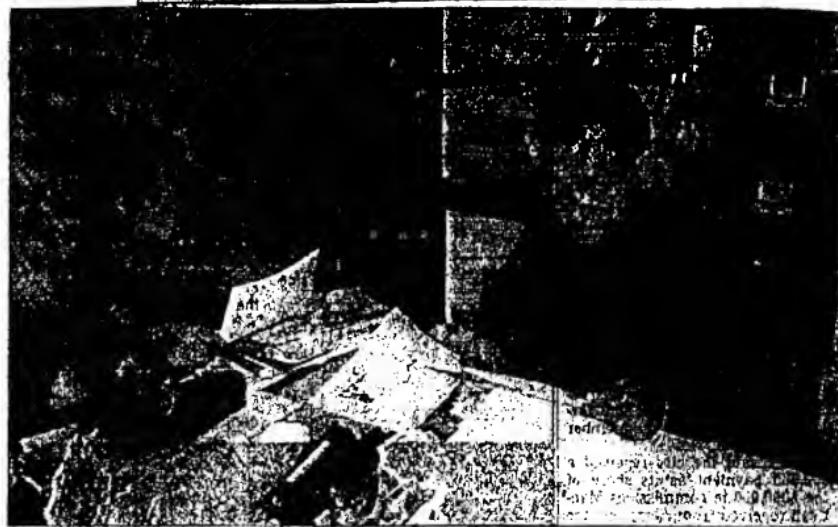
In response to your letter dated October 13, 1994, the following information is provided:

1. Who should be members of the coalition you've recommended and what should this coalition do to serve Hispanic veterans? (1) Funds should be set aside to establish offices where there is a large Hispanic Veterans community. (2) The information needed would be obtained through a survey nation wide to determine the needs of each state. (3) Each center would have an Executive Director with one Veterans Specialist, and a Case Worker, they must be bilingual (English/Spanish). (4) Assist the veteran and or his family in processing all proper documentation for claims through the Veterans Affairs. The areas cover will include: (a) Obtaining military records (b) counseling (c) Discharge upgrading (d) Compensation and Pension (e) Legal Assistance (f) Employment (g) Education and Career training (h) Medical Care (i) Provide services for Homeless Veterans (j) Housing Issues (k) Assistance in Small Business Loans (l) Case Worker for Social Security and Supplemental Security Income.
2. What are the special or unique needs of Hispanic veterans and how can the Federal government best respond to these special or unique needs? One of the biggest problems is the language barrier, the Veterans Affairs should employ a larger number of Hispanic staff within all facilities of the VA system to assist the veterans that relocate to the United States from Puerto Rico.
3. According to your testimony, veterans claims have been denied by VA in Puerto Rico and subsequently approved by VA in Massachusetts. Please provide detailed information on these claims. (ENCLOSED).

We apologize for the lateness of the documentation provided. For any additional information, please don't hesitate and call us.

Sincerely,

Agapito Rivera
 Veterans Outreach Specialist



HELPED BY VETERANS ASSOCIATION — Gumerlindo Gomez executive director of the Puerto Rican Veterans Association in Springfield, explains some paperwork to city resident Emma Rodriguez, whose husband died from a cancer that doctors said was a direct result of exposure to Agent Orange in Vietnam. The association worked to get Rodriguez the settlement for her husband's death that she was denied earlier.

Puerto Rican vets group helps widow win pension

hostile drive to the same extent as the initially dominant culture. Those USG and USM had been exposed to the dominant culture for several years, but returned to their original culture with mixed feelings. The USG had been exposed to the dominant culture for a longer period of time and had no desire to return to their original culture. Those who had been exposed to the dominant culture for less than one year had no desire to return to their original culture. The letter from the USG to the USM two weeks later was as follows:

binode and memphis blue, portland
L.A., may 1967 of deso bright
the contingent of marchers for to-
day's "Veteran's Day parade in
Springfield," add and added will
most many people do not realize
that Puerto Rican veterans of
the United States with a long tra-
dition of military service according
to local Puerto Rican vets, to
what they had done many
of the Puerto Rican people volun-
teered to serve because they are
very patriotic and they love the
country," Gomez said.

President, Oleg Gartia '36, served over two years in the 1930's, and I am proud of it. We always tried to make boy scouts with the Americans we have been there. In 1936, we had our first national jamboree African-Americans. American Indian aspect that many people didn't think we had understood. The 1937 jamboree was a turning point, because it included the Negroes. It was the first time they were invited to participate.

FOLLOW-UP QUESTIONS
TO PRESTON TAYLOR
ASSISTANT SECRETARY FOR VETERANS EMPLOYMENT AND TRAINING
FROM
THE HOUSE COMMITTEE ON VETERANS' AFFAIRS
SUBCOMMITTEE ON OVERSIGHT & INVESTIGATIONS
SEPTEMBER 28, 1994, HEARING

Question 1:

"Your testimony reports 1.8 million veterans registered with the Employment Service last year and over half a million veterans were helped into jobs. Of the 114,000 Hispanic veterans who registered, how many were helped into jobs?"

Answer:

With the exception of identifying the characteristics of those who register for services with the Employment Service, presently we are unable to collect other performance data on the basis of race, ethnicity and gender. As a result, I am unable to give you reliable data regarding the number of Hispanic veterans who were helped into jobs through the Employment Service and our Local Veterans' Employment Representative (LVER) and Disabled Veterans' Outreach Programs (DVOP). I want all of our programs to measure performance in such a way that we can identify who it is that succeeds as well as those who need more help. Unfortunately, the data we collect on the performance of our various programs is incomplete in terms of race, ethnicity, and gender. In many cases, while we may know the percentages of those who register for services according to race and gender, we do not know the success being experienced by veterans within these classifications. This is clearly a limitation in our ability to determine whether we have an effective package of services that meets the needs of all separating servicemembers and veterans. However, the collection of these data can be expensive and can impose additional burdens on the States and grantees. We are exploring ways of gathering this information so that collection is efficient, cost-effective, and least burdensome to the States and service providers, yet still meets our responsibilities to look at service outcomes.

Question 2:

"Do the added benefits, like job retention and family stability, outweigh the added costs of a veteran's "Whole Family" program as described on page five of your written statement?"

Answer:

The Veterans' Whole Family Project was funded as a one-time demonstration to ascertain the benefits that might be derived in providing an orchestrated mix of employment and training and other social service assistance to veterans and their family members who were unemployed and/or economically disadvantaged. Based on the successful performance of this

program, we believe the benefits derived from providing concurrent employment and training services to all the members of an economically disadvantaged family far outweigh the higher costs that may be required in such an intervention. However, a prevailing obstacle that service providers encounter in replicating this pilot demonstration is the difficulty in obtaining the variety of grants required to accommodate the employment and training needs of the various family members. The eligibility criteria of most employment and training legislation are too restrictive to allow a program provider to adequately serve veteran, non-veteran and youth under a single source of funding. The American G.I. Forum was able to obtain funding through three titles of the Job Training Partnership Act (JTPA) to operate its Whole Veterans' Family Project; funds from JTPA Titles IV-C, II-A, and II-B were used in concert to serve respectively the veteran, the veteran's spouse, and child(ren).

Access to such an array of funding is not frequently available to most of our service providers that target services to veterans. However, because of the diverse resources that are available in the "One Stop Career Centers" concept, we expect that there will be an increasing number of similar holistic approaches available through this emerging system to serve unemployed veterans and their families.

Question 3:

"In addition to increasing TAP participation and funding a pilot case management service program in several states, what additional attention and resources can VETS and DOL focus on unemployed Hispanic veterans? What can VETS and DOL do to more effectively serve Hispanic veterans?"

Answer:

To make continued increases in the employment of Hispanic veterans, VETS will rely on its primary delivery system, the public Employment Service, and the resources of the DVOP and LVER programs. In this regard, through the training provided by the National Veterans Training Institute (NVTI), VETS will continue to enhance the skills of DVOP and LVER staff and increase the awareness of Employment Service local office managers and supervisors of service requirements for veterans. Better trained staff are more efficient at what they do and, in the case of DVOP and LVER staff, this translates into more jobs for veterans. In Fiscal Year 1995 the DVOP and LVER programs, together, will fund approximately 3,100 positions. During the same period, NVTI will provide training for over 2,000 persons in case management, veterans' benefits, Transition Assistance Program (TAP) facilitation, and other subject areas. Although not all NVTI trainees are DVOP and LVER staff, all support work with veterans.

Each year, a significant number of veterans, including Hispanic veterans, are placed in employment through programs administered by other agencies of the Department of Labor. Preliminary data from programs funded under Titles II-A, II-C and III of the Job Training Partnership Act in Program Year 1993 indicate that of almost 53,000 veterans who were served by these programs, slightly over 3,000 were Hispanic veterans. With increases in the

appropriations for JTPA Titles II-A and III for Program Years 1994 and 1995, and anticipated improvements in the delivery of services through initiatives such as "One Stop Career Centers," we expect that a greater number of Hispanic, and other categories of veterans who are "most-in-need," will find employment through these programs.

VETS is developing a strategic plan that will target the energies and resources of this agency into the 21st Century. I assure you that the provision of services that maximize employment opportunities for Hispanic, African American, female, and other veterans who are exceedingly challenged in the search for employment, will be central to this agency's planning effort.

Question 4:

"How has Hispanic Heritage Month been recognized by and throughout DOL and VETS?"

Answer:

Secretary Reich signed a Memorandum of Understanding (MoU) with the President of the Hispanic Association of Colleges and Universities (HACU). The MoU is intended to create a partnership between DOL and HACU. It states that DOL will provide technical assistance on contract and grant opportunities, research projects, exchanges of faculty and staff, and recruitment. The MoU also provides that DOL will encourage HACU participants in training and apprenticeship pilots and model programs. We believe that strengthening the relationship between DOL and HACU will further the mission of both parties.

In addition, the Department is equally committed to fulfilling the requirements of Executive Order 12900, Educational Excellence for Hispanic Americans, issued by President Clinton on February 22, 1994. The E.O. created the President's Advisory Commission on Educational Excellence for Hispanic Americans within the Department of Education. The Commission will provide advice to the President on the development of high-quality education for Hispanic Americans. DOL is participating in the Commission.

A posthumous plaque was awarded to Cesar E. Chavez, the Hispanic champion of the labor movement. The President of the United Farm Workers of America, AFL-CIO, Mr. Arturo Rodriguez, came from California to receive the plaque. The plaque will be in permanent display in the DOL Hall of Fame.

The Bureau of Labor Statistics (BLS) sponsored a seminar featuring Dr. Edwin Melendez, Director, The Gaston Institute for Latino Community Development and Public Policy of the University of Massachusetts. The theme was "Barriers to Employment and Workplace Advancement of Latinos." BLS also sponsored a Hispanic Heritage Film series.

Dennis Rivera, President of the 1199 National Health and Human Services Employees Union and Chair of the Board of the National Rainbow Coalition, spoke to DOL employees as part of an Hispanic Heritage event.

DOL hosted a reception for its Hispanic political appointees. The Puerto Rican National

Guard band played at this event.

The Mine Safety and Health Administration sponsored a display of posters, videos, food sampling, and music from various Latin American countries.

QUESTIONS SUBMITTED BY
HONORABLE LANE EVANS, CHAIRMAN
SUBCOMMITTEE ON OVERSIGHT & INVESTIGATIONS
COMMITTEE ON VETERANS' AFFAIRS

HISPANIC VETERANS: CONTRIBUTIONS TO THE NATION
AND COMMUNITY, RECEIPT OF FEDERAL VETERAN BENEFITS AND
RELATED ISSUES.

SEPTEMBER 28, 1994

QUESTIONS FOR MR. TINO ZAMORA
NATIONAL PROGRAM DIRECTOR
NATIONAL AGENT ORANGE
TRAINING & TECHNICAL ASSISTANCE PROGRAM
AMERICAN ASSOCIATION OF UNIVERSITY AFFILIATED PROGRAMS
FOR PERSONS WITH DEVELOPMENTAL DISABILITIES
SILVER SPRING, MARYLAND

1. What needs and priorities have been identified by the Hispanic Veterans Network and who are the members of this network?

The Hispanic Veterans Network is a group formed as a result of a working forum, on Hispanic issues, during the William Joiner Center national veterans conference held in Washington, D.C. in 1994 and again in 1995.

The Hispanic Veterans Network is a group of veteran service providers and veteran advocates who decided that, informally, a mechanism needed to be established to communicate the needs and concerns of Hispanic veterans and their families.

The group is comprised of individuals representing a variety and diversity of veteran organizations and programs. The active members are as follows:

1. Carlos Martinez
Executive Director
American G.I. Forum
2. Dr. Al Bates
Regional Manager, Region 4A
Department of VA
Readjustment Counseling Services
3. Eduardo S. Rodela, Ph.D.
E.S. Rodela & Associates
Washington, D.C.
4. Francisco Bertot
Dayton Community College
Dayton, FL

5. Eugene Gilbert
County Commission
Bernalillo County
Albuquerque, NM
6. Dr. Gustavo (Gus) R. Martinez
National Deputy Director
Department of VA
Readjustment Counseling Services
7. Hector F. de Leon
Former, Special Assistant to the
Assistant Secretary for
Human Resources and Administration
Department of VA
Washington, DC
8. Art Solis
Office of Hearing Examiner
Kansas Human Rights Commission
Topeka, KS
9. Jaime Rodriguez
Research Coordinator
William Joiner Center
Boston, MA
10. Tino Zamora
National Agent Orange Training
and Technical Assistance Program
AAUAP
Silver Spring, MD

The Hispanic Veterans Network is the group that initially requested a congressional hearing on Hispanic veteran issues. That request was made to Congressman Luis V. Gutierrez in May 1993.

Other priorities of the Hispanic Veterans Network include:

- PTSD and the Hispanic Veteran
- Family issues related to veterans, especially Hispanic veterans.
- Representation of Hispanics on key VA committees and advisory boards.
- Care and services to Hispanic veterans and their families.
- Public Law 102-218 Department of Veteran Affairs Chief Minority Affairs officer
- Diversity and cultural sensitivity within the VA system.

Again the group (Hispanic Veteran Network) is an informal group that has decided to work together for the betterment of services to veterans and their families.

2. You've recommended research and surveys on the needs and problems of Hispanic veterans. Are the problems and needs of Hispanic veterans unknown?

Definitely unknown. And that is why we (the Hispanic Veteran Network and others who attend the roundtable discussions, as part of the Congressional Hearing on September 28, 1994) requested a GAO report on the status of Hispanic Veterans.

Questions and concerns like:

- Are Hispanic veterans utilizing VA benefits and services like other veteran populations?
- Are health issues of Hispanic veterans being addressed adequately?
- Is PTSD prevalent among Hispanic veterans? What about other health issues?
- Do we know the concerns and problems of Hispanic veterans and their families?
- Is language a barrier to services?
- Is culture a significant factor when dealing with Hispanic veterans?
- Is there coordination among federal agencies serving Hispanic veterans?
- Do Hispanic veterans use federal programs, designed to serve all veterans, the same as other veteran populations?
- Are Hispanic veterans represented on boards, commissions, in staff positions, etc?
- Will the Chief Minority Affairs Officer address the issues and concerns of Hispanic veterans?

The above questions are but a few of the many unanswered questions or concerns I have heard during discussions, meetings and conferences with veteran groups, regarding Hispanic veterans and their needs.

A report or study on the concerns of Hispanic veterans would help address these concerns and questions and provide a foundation for future services to this population.

3. What explains the success of the multicultural programs used by the University Affiliated Programs?

I believe the success of the multicultural programs at UAPs is based on the fact that UAPs realized that there are significant factors that need to be taken into account when addressing the needs of minorities, different cultures and under represented populations.

UAPs have begun to develop and fully implement comprehensive plans that specifically address problems and concerns associated with multicultural and diverse populations.

Training and technical assistance in multicultural areas, diversity and minority programs are "core" functions within the organization and play a key role in addressing problems and issues related to minorities, different cultures and under represented populations.

I believe the main success is because UAPs have a commitment to serving and addressing the unmet needs of these populations.

4. What are the special or unique needs of Hispanic veterans and how can the Federal government best respond to these special or unique needs? There is no doubt in my mind that Hispanic veterans and their families have special or unique needs and concerns as compared to other populations. As indicated in previous questions (above), I feel a comprehensive report or study is warranted to present facts and figures that will substantiate our concerns.

Chairman Evans to Jake Alarid, National Commander, American GI Forum of the United States

**RESPONSE TO QUESTIONS
SUBMITTED BY THE
HONORABLE LANE EVANS, CHAIRMAN
SUBCOMMITTEE ON OVERSIGHT & INVESTIGATIONS
COMMITTEE ON VETERANS**

**HISPANIC VETERANS: CONTRIBUTIONS TO THE NATION AND COMMUNITY,
RECEIPT OF FEDERAL VETERANS BENEFITS AND RELATED ISSUES**

1. How can VA outreach to Hispanic veterans be more successful, and what steps should be taken to reduce language as a barrier to Hispanic veterans receiving health care and other benefits and services from VA?

The "Hispanic Veterans" is a diverse community that spans social, cultural, and geographic dimensions. Therefore, reaching out to this community requires a plan of action that considers the distinctions. Too often, non-Hispanics view this community of Mexican Americans, Cubans, Puerto Ricans, and others as all the same. Perhaps that simplistic view is also a basis for the evident prejudice and racism that all of these Hispanic groups have experienced.

The VA's outreach would be better served by identifying the distinctions and producing efforts incorporating those distinct characteristics. Private business marketing has already experienced their learning curve with the Hispanic community and they segment their marketing campaigns accordingly. For example, in the Southwest where the Mexican American is the predominant "Hispanic," outreach would be better served by using Mexican American spokespersons, as opposed to a Cuban or a Puerto Rican. The same approach would be more effective in Miami by using a Cuban instead of a Mexican American.

The same distinctions can be served by VA reaching out through the local networks of Hispanic organizations. Hispanics in general are family oriented, and that includes extended families. If you get the message to one member of the family, then indirectly you will eventually reach the target member. This is a strategy that the American GI Forum's National Veterans Outreach Program has used effectively for many years. Their public service announcements have often reached out to the mothers and spouses of veterans, who then relayed the information they've received to the veteran. This secondary contact is actually an enhanced "pitch" because it is now presented by a loved one who usually encourages the veteran to go seek the help they need.

Other aspects that would help VA delivery of services is to recruit and provide more bilingual, bicultural staff persons and volunteers. Hispanic veterans are largely former enlisted, mostly served one tour, and are limited in the socioeconomic structure. Many of these individuals feel more comfortable in surroundings that offer the opportunity to discuss concerns, ailments, or general information needs with individuals who will understand their barriers. Hispanics are humble individuals but profoundly proud. If they encounter too many barriers that prevent them from truly expressing their problems, they would rather walk out proudly and suffer in silence, than to be subjected to the humiliation and struggle of not being able to express themselves clearly. This is an especially acute problem for the older Hispanic veterans who served in World War II and Korea, and who served at a time when a high school education was not a prerequisite.

In conclusion, I believe the VA can better serve all Hispanics by clearly understanding the distinct groups; by networking with Hispanic community groups in general and with Hispanic veterans groups in particular; and, by including more bicultural, bilingual staff members and volunteers in hospitals and service centers that geographically coincide with the Hispanic veterans community.

2. What are the special or unique needs of Hispanic veterans and how can the Federal government best respond to these special or unique needs?

The seemingly straight forward question regarding the "special or unique needs of Hispanic veterans" is a complex question made that much more difficult by the lack of health research and sociodemographic data on Hispanic veterans specifically and the Hispanic population generally. Although true, it is overly simplistic to say that the special or unique needs of Hispanic veterans include language-related issues, socioeconomic status, and sociohistorical acts of prejudice and racism against Hispanics.

For example, the National Vietnam Veterans Readjustment Study found that the prevalence rates for current post-traumatic stress disorder (PTSD) were significantly higher among Hispanic male veterans of the Vietnam Theater, 27.9 percent, than among Black and "white/other" male theater veterans, 20.6 percent and 13.7 percent, respectively. Moreover, the PTSD prevalence rates for Hispanic veterans were statistically significant even after accounting for combat experience and other variables.

To fully understand the "special or unique needs of Hispanic veterans" is to understand what Hispanics are not. First, the Hispanic population is not a unitary ethnic group. Rather, there are many Hispanic subgroups that differ from each other in terms of national origin, racial stock, and sociodemographic and cultural characteristics.

Secondly, although there are commonalities (e.g., the Spanish language, the family as a significant social structure, and religion) among Hispanics, many of these cultural orientations are undergoing modification due to intergenerational differences in acculturation and changing society.

The important Hispanic subgroups and their proportional representation are as follows: people of Mexican origin (63 percent) who reside primarily in the Southwest and West; Mainland Puerto Ricans (12 percent) who reside primarily in the Northwest; and Cubans (5 percent) who reside primarily in the Southeast. (U.S. Bureau of Census 1990)

This diversity within the Hispanic community makes it impossible to conclude on one or even several "unique" needs. The more realistic response is that the V.A. and other federal agencies need to address an array of shortfalls the Hispanic veterans have experienced in the "standard" services and entitlements available. The government needs to address the core problem of why do Hispanic Veterans get less V.A. loans; why do Hispanic Veterans use V.A. services at a lower rate than other veterans (accessibility?); why do they experience higher unemployment rates; why do they have more problems with PTSD?

These symptoms clearly show there is a problem. This problem, however, cannot be addressed by finding the "unique" needs. This is an institutional problem that must be addressed from the top and supported at every level. The message should be that, "If we are to serve all veterans equally, then we must provide unique approaches for some."



U.S. SMALL BUSINESS ADMINISTRATION
WASHINGTON, D.C. 20416

RESPONSES TO QUESTIONS SUBMITTED BY
HONORABLE LANE EVANS, CHAIRMAN
SUBCOMMITTEE ON OVERSIGHT & INVESTIGATIONS
COMMITTEE ON VETERANS' AFFAIRS

HISPANIC VETERANS: CONTRIBUTIONS TO THE NATION AND COMMUNITY,
RECEIPT OF FEDERAL BENEFITS AND RELATED ISSUES

SEPTEMBER 28, 1994

RESPONSES TO QUESTIONS FOR MR. LEON BECHET
ASSISTANT ADMINISTRATOR FOR VETERANS AFFAIRS
SMALL BUSINESS ADMINISTRATION

1. Q. According to your statement, in fiscal year 1993, Hispanic-American owned firms, which are 25 percent of SBA's 8(a) portfolio, received nearly \$1.3 billion in 8(a) contracts. What was the total amount of 8(a) contracts for fiscal year 1993?
 - A. The total amount of 8(a) contracts in fiscal year 1993 was \$4.3 billion.
 - Q. Your statement also reports that for fiscal year 1994, Hispanic-American firms have received \$803 million in 8(a) contracts as of September 1, 1994. This is about 60 percent of the amount received last fiscal year. What accounts for this difference?
 - A. Many of the 8(a) contracts are awarded at the end of the fiscal year which creates a year-end log jam in collecting data to obtain the final figures. The year-end totals are still incomplete, but the most recent figures were \$4.6 billion (\$4,573,133,917) in 8(a) contracts, \$1.1 (\$1,109,367,638) billion of which were awarded to Hispanic-American firms. These figures are still subject to correction, which means that the final figures can change.
2. Q. Why aren't there more Veteran Entrepreneurial Training (VET) programs if SBA considers this program successful? Could a Hispanic veteran or community organization sponsor this program, what is the public's investment in this program?
 - A. The Veteran Entrepreneurial Training (VET) Program was a pilot program in which we were able to demonstrate the effectiveness of long-term intensive training to assist veterans in business or going into business. In our experience, the program can be successful even using current business courses in an academic or technical training setting. Budgetary constraints, increasing demands on our budget for outreach in connection with base closings and downsizing of the military, and duplication of existing training programs have dictated our withdrawal from this program. For example, in excess of \$67 million has been appropriated to the Small Business Development Centers for training in fiscal year 1995. The entire budget for the Office of Veterans Affairs (OVA) just exceeds \$1 million. After salaries and expenses there is about \$ 500,000 for outreach and all other activities by the OVA. Any individual or organization could conduct or sponsor a similar program. The cost of our VET program averaged \$1,000 per veteran trained.

3. Q. Has SBA been denied access to any military facilities as suggested by your statement? Please identify the military facilities to which SBA has been denied access.

A. Early on in the process there was some misunderstanding about SBA's official participation as a member of the Transition Assistance Program Teams. We were able to resolve those difficulties expeditiously and currently SBA participates in Transition Assistance Training at all sites without problems.

4. Q. Where and when will the next Defense Technology Seminars be conducted and how do you intend to encourage veteran participation?

A. We are tentatively looking at the following sites (which are subject to change):

December 8-9, 1994	-	White Oak, Maryland
February 6(?), 1995	-	San Diego, California
April 3(?), 1995	-	Hanscome AFB, Massachusetts
June 5(?), 1995	-	New York, New York

We advertise in the Commerce Business Daily and local papers, list the events in the Defense Media calendars, and do a mailing to firms listed with the local technology centers and the Department of Defense subcontracting mailing list,

5. Q. How has Hispanic Heritage Month been recognized by and throughout SBA?

A. The SBA was seriously involved in Hispanic Heritage Month.

1. We ordered 120 posters and distributed them to each SBA field office. These posters were placed where they would be readily seen by employees and our SBA clients.
2. Administrator Bowles sent an SBA Information Notice: Subject: Hispanic Heritage Month to each SBA employee encouraging each of them to participate in activities planned for this year's observance of Hispanic Heritage Month.
3. The SBA's Hispanic Heritage Month Committee sent a notice to all Headquarters and Washington District Office SBA employees encouraging them to participate in a joint program sponsored by the Small Business Administration, the Department of Human Health Services, the Department of Education, the Federal Emergency Management Agency, and the United States Information Agency. Our joint program had a folkloric group, a five-person musical group that played prelude and postlude music. Our guest speaker was the Honorable Jose Lopez, Associate Judge of the Superior Court of the District of Columbia. We also had a sampling of ethnic food.
4. The SBA participated in the Hispanic Heritage Month opening ceremony for all federal agencies held at the Department of Energy.

Additionally, last August several SBA employees moderated and participated in a panel explaining SBA programs at the American GI Forum Convention at Santa Clara, California. We distributed booklets explaining the SBA's programs and talked about the 8(a) program, LowDoc loans, disaster loans, and passed on other information pertaining to SBA services.

Although we are in a freeze mode, we still encourage Hispanic veterans and non-veterans to apply for employment by the SBA.



U.S. SMALL BUSINESS ADMINISTRATION
WASHINGTON, D.C. 20416

Honorable Lane Evans
Chairman
Subcommittee on Oversight
and Investigations
Committee on Veterans' Affairs
House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

Enclosed is a corrected copy of the transcript from the hearing held September 28, 1994, on Hispanic Veterans: Contributions to the Nation and the Community, Receipt of Federal Veterans Benefits and Related Issues.

During the hearing, you had asked Mr. Bechet for information regarding the 8(a) program. In response, I have enclosed a description of the SBA's plans to address the problems of the 8(a) program through development of a Minority Enterprise Development Program. The objective of this program is to assist minority-owned firms to develop the skills and infrastructure needed to thrive in the mainstream economy. Also during the hearing, Rep. Tejeda asked Mr. Bechet for figures on direct loans to Hispanic veterans, which are provided herewith.

Finally, I have also enclosed our responses to five additional questions you sent to us after the close of the hearing.

Thank you again for the opportunity to testify at the hearing on September 28, 1994. Please let me know if there is any further information we can provide.

Sincerely,

A handwritten signature in black ink, appearing to read "Kris Swedin".

Kris Swedin
Assistant Administrator for
Congressional and Legislative
Affairs

Note: This data is provided in response to a question posed by Rep. Tejeda at the hearing. (See p. 67.)

DATA ON DIRECT LOANS TO HISPANIC VETERANS FOR FY 1994

Screened out	31
Declined	27
Withdrawn	25
Approved	204
Total Applied	287

U.S. SMALL BUSINESS ADMINISTRATION

MINORITY ENTERPRISE DEVELOPMENT PROGRAM

June 21, 1994

THE MINORITY ENTERPRISE DEVELOPMENT PROGRAM*I. EXECUTIVE SUMMARY*

The minority business community has grown considerably since the Small Business Administration first began utilizing Section 8(a) of the Small Business Act as a way of reaching out to this segment of the population. The level of sophistication and diversity of minority-owned businesses has increased, consistent with development of the economy. However, the underlying problems in our society which necessitated the 8(a) Program – the lack of access to information and capital for minorities – has not changed as dramatically. While there are a number of sizable minority-owned firms, including several that have gone public, minorities are not fully represented in business ownership and still do not have equal access to the tools necessary to fulfill the American dream of owning and growing one's own business.

In the past, the efforts of the Small Business Administration to assist the minority business community, unlike its efforts to assist other small businesses, have focused almost exclusively on providing access to and assistance with government contracting. While this is a valuable tool in the development of any company, this approach has not produced a meaningful "survival rate" after program participation. Companies exiting the program did not have sufficient business outside the 8(a) Program and/or a strong enough capital base to enable them to survive in the mainstream economy.

In an attempt to address the problems of the current program and to reflect the realities of the American economy of the 90s, the SBA has developed a Minority Enterprise Development Program that seeks to address some of these issues. Utilizing all of the resources of the Small Business Administration, including government contracting, this program seeks to serve larger numbers of minority-owned firms and to provide them with the tools necessary to become viable businesses.

The proposed program supports the Clinton Administration's commitment to ensuring that minority-owned firms have equal access to the managerial and financial assistance necessary for a business to prosper and grow. The minority business community can and must play a vital role in the revitalization of the American economy and in the creation and maintenance of jobs.

The proposed program, the Minority Enterprise Development Program (or "MED" or the "Program"), was developed after months of talking with our customers in Town Hall meetings and brainstorming sessions around the country. We conducted a letter survey of 8(a) Program participants and had meetings with individual companies, representatives of trade associations, and other Federal Government agencies. We sought input from Members of Congress and their staffs. We also talked with SBA employees, especially those in the field who work directly with our customers. The program that we have developed represents the collective ideas and suggestions of all of these groups.

PROGRAM OVERVIEW:

The Program presented herein is a broad outline of a new approach to assisting minority-owned businesses; detailed provisions will be necessary for full implementation. The focus of the Program is developing businesses, starting at the initial stage of establishing the business, and utilizing all of the resources available to the Small Business Administration, its resource partners and sister agencies, to promote and assist in the development of minority-owned businesses.

The objective of this Program is to assist a minority-owned company to develop to the point where it has the skills and infrastructure necessary to thrive in the mainstream economy.

The Program has been developed in three (3) phases with the emphasis during the first two phases on providing business training and assistance appropriate for a company at that level. Entry into Phases I and II would be based primarily on self certification of qualifying status, but SBA will maintain the right to rebut any claim of social and economic disadvantage status. Entry into Phase III would be approved by the District Office based on a completed application which would include meetings with the company and a visit to the company's offices.

While the Program has been designed to provide assistance in three phases, it is important to note that the phases are not necessarily meant to be a sequential, progressive path for all firms. A firm may enter and complete any stage in which it qualifies.

The Program has been designed to help participating firms compete; the Program does not guarantee success, or even that a company will remain in business. It will, however, in collaboration with other Federal agencies, offer the business management, technical assistance, and access to capital that will assist a company in its efforts to grow. It is not necessary for a company to engage in government contracting to participate in Phase I or II of the proposed Program.

Training is a key element of both Phases I and II. SBA proposes to establish a position within the Program that will be responsible for coordinating the Program's training efforts. This position, the National Training Coordinator, would be responsible for identifying core training needs, identifying supplemental training needs for certain industries or parts of the country, identifying sources for obtaining and financing the training, and

establishing and monitoring training programs with SBA field offices and Program participants. We will actively seek private sector participation in developing and delivering training for our staff and Program participants.

Phase III of the Program will utilize SBA's section 8(a) contracting authority; however, SBA will provide more comprehensive assistance to participating companies to enhance their ability to do business with the Federal Government. Under the new Program, as with the current one, the Program participant will be responsible for obtaining contracts. In Phase III, SBA will also work more closely with the companies to assist them in developing other government business.

Increasing the number and quality of Program participants will provide government agencies with more qualified firms to perform contracts. Other features of the Program will increase government contracting opportunities by making it easier for Federal agencies to contract with small disadvantaged businesses. SBA proposes to delegate all authority for contract award and execution to the procuring agencies. This would significantly reduce the time and paperwork involved in the 8(a) contracting process, and make it easier for government agencies to do business with minority firms. SBA would work closely with the government agencies to develop appropriate Program goals to include the dollar value of contracts, the number of contracts and the number of contractors. SBA would participate in contract negotiations only upon the request of the Program participant or the contracting officer.

The Program would also offer participants greater access to capital by pre-qualifying working capital lines of credit for companies in need of financial assistance.

Many firms have received 8(a) certification, but have been unable to take advantage of the contracting opportunities available in the Program; accordingly, companies which have been in the 8(a) Program for 3 years or less and have not received any 8(a) contracts would be offered the opportunity to suspend their current Program participation term and participate in Phase II to obtain the necessary management and technical assistance to develop their firms. These firms would remain eligible for an 8(a) contract award and their Program participation would resume upon the award of an 8(a) contract. While this feature would assist more firms in taking full advantage of the 8(a) program, it would not extend their active Program participation term.

II. HISTORY OF THE SMALL BUSINESS ADMINISTRATION'S INVOLVEMENT IN MINORITY ENTERPRISE DEVELOPMENT

The Small Business Act of 1953 authorized SBA, under section 8(a) of the Act, to enter into contracts with Federal agencies and to subcontract the work to small businesses. However, for 15 years SBA did not use the section 8(a) authority.

The 8(a) Program evolved as a result of Executive Orders issued by Presidents Johnson and Nixon in response to the 1967 Report of the Commission on Civil Disorders, commonly called the Kerner Commission. The finding that triggered the 8(a) effort was that disadvantaged individuals did not play an integral role in America's free enterprise system, in that they enjoyed no appreciable ownership of small businesses and did not share in the community redevelopment process.

In 1967, President Johnson ordered that the section 8(a) authority be used to direct contracts to businesses located in distressed urban areas in order to create jobs.

In 1969, SBA redesigned the Program to provide Federal contract support for small firms owned by socially or economically disadvantaged individuals. The 8(a) Program grew in a 10-year period from 1970 to 1980 to include approximately 2,000 firms.

In 1978, Congress enacted Public Law 95-507 to provide the Program with statutory authority. The law provided a number of measures to shift the Program's focus to business development and required that Program participants be at least 51% owned and controlled by socially and economically disadvantaged individuals.

It also created the position of Associate Administrator for Minority Small Business and Capital Ownership Development (AA/MSB&COD) to administer the 8(a) and 7(j) management and technical assistance programs. Prior to this, the 8(a) Program was administered by the Associate Administrator for Procurement Assistance and the 7(j) Program was administered by the Associate Administrator for Management Assistance. P.L. 95-507 also detailed specific eligibility criteria and required that all determinations be made by the AA/MSB&COD.

Unfortunately, even with P.L. 95-507 the program failed to develop viable competitive firms that would graduate from the program and survive in the marketplace.

As a result of so few firms leaving the Program, in October 1980, Congress passed P.L. 96-481. This law required SBA to negotiate a fixed period of time for participation, and definite graduation dates with all 8(a) firms. Prior to this there was no time limit on participation in the Program.

Through regulations, SBA established the fixed program participation term (FPPT) which limited a firm's participation in the Program to an original term of up to 5 years with a possible extension of 2 years. Full implementation of these regulations took place on April 21, 1982.

On November 15, 1988, President Reagan signed into law the "Business Opportunity Reform Act of 1988," P.L. 100-656. This law provided for, among other things, competition in the 8(a) Program; a nine-year participation term; attainment of non-8(a) revenue at certain levels during Program years 5 through 9; an 8(a) loan program; transfer of surplus property; employee skills training; establishment of the Division of Program Certification and Eligibility that would process applications within 90 days; Miller Act surety bond exemptions; Walsh-Healey Act exemptions; business plans prior to award of any 8(a) contracts; and, a transition management plan during the first year of the transition stage. It also required SBA to submit an annual report on the Program to the Congress.

In spite of the efforts of previous Administrations, the 8(a) Program still does not provide adequate assistance to minority-owned firms to enable them to compete in the mainstream of the American economy.

While the application processing time has (as of April, 1994) been reduced to an all-time low of 96 days, the Program still has not met many of its primary objectives. Currently, only 46% of 8(a) certified companies are receiving contracts; anticipated data collection and automation improvements have not been completed; Federal procuring agencies have not provided adequate contract opportunities to the portfolio; and, the agency's business development assistance is in need of improvement.

While some of these issues can be addressed administratively, the time has come to evaluate the entire Program and the system of service delivery. Until the minority-owned business community is able to participate fully in the mainstream American economy, we will not be able to achieve the full growth and development of our economy. Moreover, a large segment of our population will be denied full access to the American dream.

III. BACKGROUND TO DEVELOPMENT OF THE PROPOSED PROGRAM

The evaluation of the 8(a) Program began by talking with our customers and constituents.

In August 1993, Administrator Bowles wrote to every 8(a) firm in SBA's portfolio requesting their comments and suggestions on the issues of: 1) facilitating Program entry; 2) streamlining the monitoring system; 3) providing ongoing business development assistance, 4) developing a rapport with government purchasing agencies to expand contract opportunities; 5) establishing a mechanism to work with 8(a) Program graduates; and, 6) improving the Program success ratio. We received over 300 responses to the 4,500 letters mailed.

In October 1993 SBA brought together a cross-section of 8(a) firms from across the country for a brainstorming session. The session included African-American, Asian-American, Hispanic-American and Native-American owned firms. These firms were engaged in manufacturing, professional and non-professional service delivery, and high technology research and manufacturing. There were 8(a) graduates who were still quite successful, as well as companies whose businesses had declined precipitously after leaving the Program. There were recent Program entrants who had yet to obtain their first contract, as well as companies that were midway through the Program and had received a considerable amount of government business. Companies that were exporting and had foreign offices, as well as companies that wanted to explore international markets, also participated in these sessions.

Our first session was also attended by Federal agencies with independent minority contracting programs, such as the Department of Defense and NASA, as well as other agencies that use the 8(a) Program. In addition, our initial session was attended by staff members from the House Small Business Committee and the House Small Business Committee's Subcommittee on Minority Enterprise.

This first session was so informative and the interest in providing input was so great that we held six additional sessions around the country: in Los Angeles, Dallas, Chicago, Philadelphia, Atlanta and a second session in Washington, D.C. (to solicit input from the trade associations and local minority-owned businesses).

In addition to confirming the dissatisfaction with the structure and operation of the existing program, these sessions also confirmed that the primary problems confronting minority-owned businesses are lack of access to information and capital. It was also made clear that SBA's program to assist minority-owned businesses had become focused on contracting and not on the development of viable minority-owned businesses. We discovered that the majority of the 8(a) firms were not aware of the other programs and services offered by the SBA, and were not utilizing these programs and services. Clearly, this segment of the market has been inadequately served by the SBA.

With the help of our customers and constituents, we have developed a comprehensive program to address the issues raised by our customers, the minority-owned firms, and our partners in assisting them, the Federal procuring agencies.

IV. THE PROPOSED MINORITY ENTERPRISE DEVELOPMENT PROGRAM**A. Phase I: START-UP (For Entrepreneurs and Start-Up Companies)**

The objective of the first phase of the Minority Enterprise Development Program is to provide a budding entrepreneur or a start-up company with the basic knowledge and skills necessary to establish a company and get it operational. The maximum period of participation in Phase I would be two years from the date of self-certification. However, a company could complete this phase in less than two years. Withdrawal and reentry would be permitted with SBA approval.

1. Eligibility Criteria - in order to enter this phase of the Program, a company or an individual must meet the following criteria:

- An individual starting a business must be socially and economically disadvantaged, or an existing small business must be at least 51% owned and controlled by socially and economically disadvantaged individuals ("qualifying individual"). The qualifying individuals need not devote full time to the management of the business.
- Qualifying individuals must be U.S. Citizens.
- An existing business must be operational less than two (2) years, as of the date of initial certification.

Applicants will complete a one (1) page application, along with the SBA Form 912, Personal History Statement, available at any SBA office or Minority Business Development Agency (MBDA) office, certifying as to the eligibility criteria. SBA District Office officials will have the authority to approve the applications, and approval can be granted immediately in most cases.

Following self-certification and enrollment in Phase I, the candidate will be assigned to an SBA Business Development Specialist ("BDS") in the District or Branch office, who will be responsible for assisting the firm in developing an individualized training plan and training schedule, based on the generic training program developed by SBA's National Training Coordinator. Prior to developing the training plan, the candidate should have attended the SBA Pre-Business Workshop and have been provided an orientation on SBA and other business development programs.

2. Potential Program Benefits - During Phase I of the Program, the company will have access to the following training and assistance in an organized, systematic manner:

- Orientation on all SBA Programs and other Federal, state, and local business development programs;
- Pre-business workshop;
- Small Business tax workshop;
- Basic accounting and bookkeeping/establishing a basic accounting system;
- Preparation of a marketing plan;
- Preparation of a business plan;
- Preparing a loan application;
- Bid/proposal preparation;
- Small purchase procedures; and,
- Financial management.

The training and assistance included in the plan would be based on the needs of the individual program participant and could be modified and revised as needed. For example, if the individual is not interested in government contracting, the training plan should not include training on small purchase procedures, etc.

3. Service Providers - the assistance indicated above would be coordinated by SBA District Offices and provided by the following:

- SBA - through the 900 Small Business Development Centers and Subcenters, the 13,000-member Service Corps of Retired Executives (SCORE), the 500 Small Business Institutes, and SBA's Government Contracting Program;
- Minority Business Development Agency ("MBDA") - through its Minority Business Development Centers, the Native American Development Centers, and MEGA Centers;
- Other government agencies, such as the Internal Revenue Service, Technology Centers and the General Services Administration, through existing training programs and pilot projects; and,
- Universities, community colleges, trade associations, other private institutions and mentors - the Phase I training program will be developed at the local level with the assistance of the MED National Training Coordinator.

4. Completion Criteria - SBA will issue a Phase I Completion Certificate upon completion of the following:

- Completion of the required training plan;
- Preparation of a Business Capability Statement or Marketing Brochure;
- Successful award of one or more small contract(s) or purchase orders (government or commercial) or substantial achievement of projected revenue;
- Preparation of financial statements; and,
- Establishment of a business bank account.

5. Measures of Success - SBA intends to evaluate the Program's success in this phase by considering the following factors:

- Percentage of firms who successfully complete Phase I;
- Number of individuals that actually start a firm;
- Number of contracts, purchase orders or substantial achievements of projected revenue;
- Dollar amount of contracts received;
- Number of hours of training received; and,
- Numbers of jobs created while in Phase I.

The information needed to evaluate these factors will be obtained by conducting exit surveys of firms as they leave Phase I to go on to Phase II, or simply leave Phase I.

B. Phase II: DEVELOPMENTAL (For Companies with Some Business Experience/ Operations)

The second phase of the MED Program seeks to assist companies that are beyond the start-up stage, and are beginning to develop the business infrastructure and systems necessary for continued growth. Phase II is designed for maximum flexibility to accommodate the specific needs of a variety of minority small businesses, including those that are reasonably successful, those seeking to provide goods and services to their communities, as well as those interested in government contracting. The maximum period of participation in Phase II will be three (3) years from the date of entry. The company would be permitted to withdraw and reenter with SBA approval. Of course, the Program could be completed in less than three (3) years.

1. Eligibility - the company would have to meet the following criteria:

- It must be an existing small business at least 51% owned and controlled by socially and economically disadvantaged individuals (qualifying individuals);
- The qualifying individuals must be U.S. citizens;
- The business must be operational at least two years, evidenced by tax returns showing revenue for each of the previous two years. OR must have satisfied Phase I completion criteria; and,
- It must currently have a full-time management team.

Applicants would complete a one (1) page application and SBA Form 912, available from any SBA office or other service provider, certifying as to the required eligibility criteria. The application form will require information on the business operations, client/trade references, management team, accounting system and business plan. SBA District Offices would have the authority to approve the application, and in most cases approval could be granted immediately. Upon approval, the company will be provided an orientation on SBA and other developmental assistance programs.

The company would be required to execute a written Developmental Agreement as a condition of receiving Program benefits. This document would contain the commitment of the firm to complete any required training within a specified period of time, and a commitment to advise SBA of any change in its eligibility. The Developmental Agreement would also contain a commitment from the BDS on behalf of SBA to assist the firm in obtaining the necessary training and assistance agreed upon in the plan. This phase would require at least one visit to the company's office by the BDS.

2. Potential Program Benefits - during Phase II of the Program, the company's developmental plan may include training and assistance in the following areas as needed and agreed upon by the BDS and the company:

- Strategic planning
- Marketing-Advertising-Sales
- Management training
- Personnel management training
- Tax planning
- Construction management (if applicable)
- Electronic data interchange training
- Procurement training
- Business planning
- Financial management

3. Service Providers - the assistance indicated above would be coordinated through the 68 SBA District Offices and provided by the following:

- SBA - through the 900 Small Business Development Centers and Subcenters, the 13,000 member Service Corps of Retired Executives (SCORE), the 500 Small Business Institutes, and SBA's Government Contracting Program;
- Minority Business Development Agency ("MBDA") - through its Minority Business Development Centers, the Native American Development Centers, and MEGA Centers; and,
- Universities, community colleges, trade associations, and other private institutions.

As with Phase I, Phase II training will be developed at the local level with assistance from the MED National Training Coordinator.

In addition, the Program's National Training Coordinator would work with the Department of Defense and the Office of Federal Procurement Policy's Federal Acquisition Institute to develop a comprehensive training program in Federal Government Procurement. This type of training is vital to increase the likelihood of the firm's success if it plans to participate in Phase III.

SBA will also work with its commercial bank partners to develop training seminars in cash management and building banking relationships for Program participants. The training will be designed so that it is beneficial to firms in different industries as well as those firms that may not be interested in government contracting.

4. Completion Criteria - SBA will issue a Phase II Certificate of Completion upon the following:

- Completion of the developmental agreement;
- Successful award of three or more small contracts/purchase orders or substantial achievement of projected revenue;
- Completion of a Comprehensive Business Plan, Capability Statement and Marketing Brochure;
- Preparation of Annual Income Statement and Balance Sheet and Business Tax Returns; and,
- Establishment of a credit relationship if needed (bank or trade credit).

5. Measures of Success - SBA intends to evaluate the Program's success in this Phase by considering the following factors:

- Number of firms that complete Phase II, and are qualified to enter Phase III (whether or not they choose to enter Phase III, or have an improved business condition from point of entry into Phase II, or complete their Development Agreement; and,
- Number of contracts received;
- Dollar amount of contracts received;
- Number of hours of training received; and,
- Numbers of jobs created while in Phase II.

The information needed to evaluate these factors will be obtained by conducting exit surveys of firms as they leave Phase II to go on to Phase III, or simply leave Phase II.

C. Phase III: GOVERNMENT CONTRACTING [8(a) Contracting and Business Development]

The third phase of the Program will utilize the section 8(a) sole source contracting authority, in addition to management and technical assistance tools, to further assist in the development of the firm. The 8(a) contracting process would be streamlined by having SBA delegate the contract award function to the procuring agencies. SBA would continue to be responsible for accepting procurement opportunities into the 8(a) Program and notifying the procuring agency of the program participants' eligibility.

To ensure that firms do not become overly dependent on 8(a) contracts for their survival, SBA will continue to require that firms participating in Phase III meet competitive business mix requirements. SBA will also develop procedures for the BDSs to assist companies in correcting the problem of over-reliance on the 8(a) program. SBA will require that participating companies attempt to maintain at least the dollar amount of business the company had when it entered the program for its first four (4) years of Program participation. Thereafter the company will be required to meet the following business mix requirements:

<u>Program Participation</u>	<u>Non 8(a) Business Requirement</u>
Year 5	15-25%
Year 6	25-35%
Year 7	35-45%
Year 8	45-55%
Year 9	55-75%

The maximum period of participation in Phase III would be nine years from the date of certification into Phase III by SBA.

1. Eligibility Criteria - SBA's District Offices shall certify firms for this phase upon a positive determination based on a written application, that the firm:

- Is an existing small business that is at least 51% owned and controlled by individuals who are socially and economically disadvantaged (qualifying individuals);
- Has been in operation for at least two years, as evidenced by tax returns and financial statements;
- Is managed on a full-time basis by an individual who has completed a Phase II developmental agreement, or otherwise demonstrated the existence of business experience, managerial or technical expertise in the firm's primary industry;
- Its qualifying individuals are U.S. citizens;
- Anticipates Government contracting opportunities within its area of experience and/or expertise;
- Has a record of successful performance on government or non-government contracts in its primary industry;
- Has established credit with a financial institution; and,
- Has bonding, if applicable.

Applicants will need to complete an application form which would be available at any SBA office or service provider. The application will require information on business operations, client/trade references, management team, accounting system and business plan. It will also require information on the responsibility for day-to-day operations and management, government contracting opportunities, available lines of credit and personal economic and social circumstances of qualifying individuals who control the firm. Approval may be granted by the District Director following a review of the information submitted, and recommendations by the BDS, BDS's supervisor and a review by District

Counsel. This process will have built into it at least one visit to the company's offices by the BDS and at least one meeting between the District Director (or designee) and the applicant prior to a decision. Applicants declined by the District Director may request a reconsideration by the AA/MED or designee, with a further right of appeal, as is currently the process.

2. Potential Program Benefits - during Phase III, Program participants would have access to training and assistance in the following areas, which would be provided primarily through the 7(j) program:

- Strategic planning
- Executive development
- Federal procurement
- Marketing
- Financial management
- Industry specific technical assistance
- Sole source contracting
- SBA loan guarantees
- Transfer of technology or surplus property

3. Service Provider - training in Phase III would be funded primarily by SBA's 7(j) Program. SBA will expand the Executive Development Program undertaken with the Amos Tuck Minority Business Executive Program to include other schools, and to provide more training in executive development. Advanced training would also be available to Phase III participants through MBDA and through SBA's other partners, such as commercial bankers.

4. Completion Criteria - Program participants may exit the Program (with no right of reentry) in one of the following ways:

- Completion of the nine year term;
- Voluntary withdrawal (companies that voluntarily withdraw prior to receiving an 8(a) contract may be readmitted at the sole discretion of the Administrator); or,
- Termination for cause.

5. Measures of success - SBA intends to evaluate the Program's success in this Phase by considering the following factors:

- Number of firms viable three (3) years after completion of Phase III (viability would include firms still in operation as independents and those which have been acquired by other businesses);
- Number of firms able to obtain or retain needed credit or bonding;

- Number and percent of firms that have substantially achieved competitive business mix targets;
- Number of contracts received (this would include contracts received through 8(a), SDB set-asides, small business set-asides, and unrestricted competition);
- Number of contractors and percentage of portfolio receiving contracts;
- Dollar amount of contracts received; and,
- Numbers of jobs created while in Phase III.

The information needed to evaluate these factors will be obtained by conducting exit surveys of firms as they leave Phase III, as well as by follow-up surveys mailed three (3) years after exit.

Recognizing that entrepreneurs will have varied backgrounds and experience, it is possible for a company to enter the MED Program at any phase, depending on the individual company's capabilities.

V. ACCESS TO CREDIT AND EQUITY CAPITAL

While managerial advice and information about business opportunities are important, growing companies must have access to all forms of capital – not just debt capital. SBA recognizes that a program that seeks to provide meaningful assistance to minority-owned businesses must also provide access to capital.

The 8(a) Program has not provided access to capital to participating companies. Moreover, in an effort to guard against abuse of the Program, the Program severely restricts Program participants' ability to access capital by restricting the net worth of the qualifying owner, which limits a company's borrowing base.

We recognize that banks certainly will require a personal guarantee of a small company 51% owned by one individual. To provide 8(a) firms an additional opportunity to obtain debt financing to grow their businesses, SBA proposes to raise the net worth limits to \$300,000 (from \$250,000) for entry, and to \$900,000 (from \$750,000) to remain eligible for program participation. This increase reflects a 19.5% cumulative adjustment for inflation since this restriction was enacted in 1989.

The current requirement that the qualifying owner(s) retain 51% of each class of voting stock and 51% of the aggregate of all outstanding shares of stock, restricts the company's ability to obtain equity. The owner must purchase enough of any new stock issued to

maintain 51% ownership, or any additional shares issued must be purchased by another "qualifying individual", so as to maintain 51% minority ownership of both the voting stock and the aggregate of all shares outstanding. It is important to balance the goals of the 8(a) Program (in this case, fostering company ownership by minorities) with a company's need for capital in order to grow.

To enable 8(a) firms to access equity capital, SBA proposes to permit MED participants who have been in Phase III at least three (3) years, who are in industries requiring a significant investment in plant and equipment, and who must increase the capital base of their firms in order to grow, to reduce the ownership of the qualifying individuals to no less than 35% of the aggregate shares outstanding. The company must be a participant in the Program in good standing (defined in Program operating procedures); the qualifying individual(s) must continue to own the largest single block of shares and maintain control of the daily operations; and the qualifying individual(s) must continue to own at least 51% of the outstanding voting stock.

As an additional option for raising equity for Program participants, SBA proposes to increase the permissible investment by non- 8(a) firms to increase their investment into participating 8(a) firms from 10% to 20% of the shares outstanding, subject to approval by the Administrator. The firms may be in the same or similar lines of business, but must have separate identities and operations.

PRE-QUALIFICATION/ INCREASED GUARANTY FOR SBA LOANS - Working with the MED staff, the Financing Division would review the financial condition and projected needs of all Phase III [8(a)] firms. Based on the firms' financial condition, SBA would pre-qualify a level of credit for each firm tied to the company's contracting activity. The pre-qualification letter could be used to demonstrate that the firm has the financial capability to perform on contracts. The pre-qualification letter could also give the company the leverage it needs to induce a lender to act favorably on a request.

To provide additional support to companies in the MED Program, and recognizing the problems minority-owned firms have in obtaining credit (as evidenced by the small percentage of loans to minorities in SBA's own loan portfolio) the MED Program will offer a higher guaranty on revolving lines of credit to creditworthy Program participants, as follows:

- 95% Guaranty on loans to Phase III [8(a) certified] firms for the financing of government contracts;
- 90% Guaranty on loans to Phase III for [8(a) certified] general working capital loans or lines of credit to support non-government contracts; and,
- 85% Guaranty on loans to minority owned [but not 8(a) certified] firms for the purpose of financing government contracts.

The proposed increases in SBA's guaranty as outlined above are expected to have very little impact on SBA's overall average guaranty percentage, as these loans will be a very small percentage of the overall loan portfolio.

VI. GRANDFATHERING PROVISIONS

SBA will undertake a review of the existing portfolio of 8(a) firms to assess their appropriate stage of development. We recognize that many current 8(a) Program participants do not have the business infrastructure or marketing expertise necessary to be active government contractors.

- Firms participating in the current program that have not received a section 8(a) contract will be offered the opportunity to participate in Phase II of the new program.
- Firms agreeing to participate in Phase II will be required to execute a Developmental Agreement. The 8(a) Program participation term will be suspended at that point and would resume if the company is awarded a contract while participating in Phase II of the Program, or when the developmental agreement is completed.
- Those firms that do not choose to participate in Phase II will continue through their nine-year term.

VII. CONTRACTING OPPORTUNITIES

In order to expand the procurement opportunities for all small disadvantaged businesses, SBA is proposing that the Small Disadvantaged Business Set-aside program at the Department of Defense (1207) be expanded to include all Federal agencies. With a Government-wide competitive minority set-aside program, the 8(a) Program would be used exclusively as a sole source program.

Further, SBA proposes that a ceiling for individual sole source contract awards be established at \$10 million for manufacturing contracts and \$7 million for service and construction contracts and for all other types of contracts, including requirements and Indefinite Delivery and Indefinite Quantity (IDIQ) type contracts, based on the total estimated contract value including options. This provision would include a waiver to exceed these ceilings for firms located in Empowerment Zones and areas of high unemployment, on Indian Reservations, as well as tribally-owned firms and/or firms which utilize individuals from these areas to perform at least 50% of the labor required to complete the contract, provided the firm is in compliance with all other program requirements.

The practice of designating contracts as local and national buy will be eliminated so that Phase III participants may self-market for 8(a) contract opportunities on a national level.

The Agency would also eliminate the requirement that Indian-owned 8(a) firms obtain a waiver from the Buy Indian Act to perform an 8(a) contract.

As mentioned earlier, SBA proposes to delegate the 8(a) contract award function to procuring agencies. SBA would work with the procuring agencies to develop the broadest possible array of contracting opportunities for MED firms by revising the procurement goaling process to require agencies to include goals for the number of contract awards and the number of different contractors, in addition to the dollar goals. SBA would remain responsible for verifying eligibility of participating firms.

As part of the delegation of authority, SBA would require that procuring agencies be required to provide the Agency with a timely written response to its request to set aside a specific contract (and explanation for the denial, if applicable) to strengthen the Agency's ability to identify and provide contract support for program participants.

The limitation on the number of 8(a) contract awards a firm can receive will be eliminated, as long as the company is meeting its competitive business mix requirements. Limits would be imposed if the company requires a remedial action plan.

The restrictions on adding Standard Industrial Classification (SIC) Codes would be eased. SBA will allow firms to add additional SIC Codes as long as a rational business explanation exists for acquiring the SIC code.

VIII. TEAMING ARRANGEMENTS

A major criticism of the 8(a) Program has been the low "survival rate" of 8(a) firms. There are several factors which contribute to this:

- The length of time required to learn the procurement process and develop the marketing skills means that few firms actually have nine full years of Program participation;
- The high dependency on 8(a) contracts of many Program participants, such that when the fixed program participation term of nine years expires, there is a precipitous drop in the firms' business volume; and,
- Program restrictions that prevent firms in the same or similar lines of business from working together.

As a result, the Program has not been particularly successful in assisting the development of viable firms which are able to sustain themselves after completion of the Program.

A Mentor/Protege Program (using the existing Program at the Department of Defense as a guide) would utilize the "know-how" that experienced, successful firms have acquired in supporting and educating companies new to the Program. An additional benefit would be a smoother transition for the graduate 8(a) firms into a wholly competitive market. To facilitate cooperative relationships between Program participants, we propose the following teaming arrangements:

- Joint Ventures - between two participating 8(a) firms, in which the two entities would join forces to perform a single 8(a) contract and would be exempt from SBA's affiliation rules.
- Sub-contract - a participating 8(a) firm would serve as the prime contractor, performing the required percentage of the work on the contract (at least 50% on manufacturing and service contracts; 15% on general construction; and 25% on specialty construction).
- Mentor/Protege - a contractual relationship between a participating 8(a) firm and a Program graduate which completed the Program in "good standing". The Mentor would provide technical, managerial and financial support to the Protege without violating SBA's size affiliation rules and would be able to continue to receive 8(a) sub-contract work as stated above. Specifically, Mentors must be capable of providing Proteges with access to markets, assistance in building the Proteges' infrastructure, technology transfer and financial support. The Protege must have been in Phase III for at least three years, but no longer than six years. There is no limitation on the number of contracts the parties may pursue, so long as the Protege performs the required percentage of the work on each contract.

Joint venture and sub-contracting arrangements must be reviewed and in compliance with SBA regulations. Mentor/Protege arrangements must be approved by the AA/MED.

To further strengthen participating firms' ability to survive after Program completion, SBA proposes to permit procuring agencies to award an 8(a) sole source contract to a Program participant after Program completion, provided the company had submitted a contract offer, which included price, and was eligible for the award at time of completion.

IX. PARTICIPATION OF COMMUNITY DEVELOPMENT CORPORATIONS

Public Law 97-35 (1981) required SBA to promulgate regulations to ensure the availability of the 8(a) Program to Community Development Corporations (CDC). SBA has not heretofore implemented this authority through regulations. Proposed regulations have now been developed to make CDC-owned or -financed companies – but not the CDC itself – eligible for the 8(a) Program. These companies would be subject to the same rules and regulations as other Program participants.

X. REDUCTION IN BURDENOME REPORTING REQUIREMENTS

A key component of the redesign of the 8(a) Program is the reduction in the burdensome reporting requirements that do not improve program delivery, nor enhance program participation. Included in the requirements to be reduced or eliminated are the following:

- Elimination of the submission of quarterly financial statements, except when needed to determine financial capacity as it relates to an individual contract or part of a determination for continued program eligibility, or as part of a loan application;
- Annual rather than semi-annual reports on fees paid to representatives and consultants for assistance in obtaining a federal contract;
- Permission for firms to submit the 8(a) business plan or its business plan on its own form and format, provided that the plan includes a thorough analysis of the company, its market, goals and objectives and plans (including financing requirements) for achieving its goals. SBA would continue to provide assistance, through its resource partners, in preparing and maintaining business plans;
- Elimination of the statutory requirement for the submission of a "transition management plan" during the first year of the transitional stage; and,
- Annual reports on the company's competitive business mix (as defined on pages 12 and 13), based on the company's fiscal year, rather than on the anniversary of program entrance.

CONCLUSION

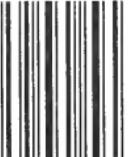
The above proposal represents the collective ideas and efforts of the minority small business community and their trade associations, some Members of Congress, representatives of several Government Agencies, and the Small Business Administration.

We look forward to working with all of the individuals and groups who assisted in developing the proposed Minority Enterprise Development Program to make the Program a reality.

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